Peach County Schools
CREATING EXCELLENCE

PERMISSION CARD FOR PARTICIPATION IN ATHLETICS IN PEACH COUNTY SCHOOLS

I/We, the undersigned, being the parent(s)/guardian(s) of _______________________________, a student in Peach County Schools, hereby grant permission for said student to participate in the physical activities or athletic program carried on at or by said school, and with the express understanding that neither said school, nor the Board of Education of Peach County, nor employee of said Board of Education or of said school is liable or shall be held liable for any loss, damage, or injury sustained by said student, or the undersigned caused by or resulting from the participation of said student in any practice, game or contest, or in traveling to or from any practice, game, or contest.

I/We realize that such activity involves the potential for injury which is inherent in all sports. I/We acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observance of rules, injuries are still a possibility. On rare occasions these injuries can be so severe as to result in total disability, paralysis or even death.

This permission is effective as of this date and shall continue so long as said student is a student at said school unless revoked by the undersigned in writing and delivered to the Superintendent of Peach County Schools.

Given our hands and seals, the _________ day of ______________, 2010

_______________________________ _______________________________
Parent/Guardian Parent/Guardian

We give our permission for the coaches to treat injury. We also give our permission to take our son/daughter to the doctor for medical treatment, if necessary.

____
Parent/Guardian

Parent(s)/Guardian(s) Name _______________________________
Please print

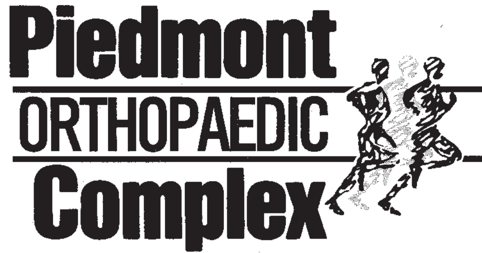
Home # _____________________ Work # _____________________

Closest relatives to get in touch with in case you are unavailable

Name _______________________________ Phone _____________________

523 Vineville Street | Fort Valley | GA 31030 | phone 478.825.5933 | fax 478.825.9970 | peachschools.org

Practice Limited To
Sports Medicine and
Orthopaedic Surgery



Walter P. Barnes, Jr., M.D.
(1927-2000)
Bill Barnes, M.D.
Layne Myers, M.D.
Dr. Jeffrey Burnette, M.D.
Dr. Pamela Onderko, D.P.M.
Paul Peterson, P.A.

ATHLETIC THERAPY & REHABILITATION INSTITUTE
(ATARI)

HIPPA ATHLETIC CONSENT FORM

Dear Parent/Guardian:

As of April 7, 2003, HIPPA implemented a patient *Right of Privacy Act.* In accordance with this act, every patient must be advised of their right to privacy **BEFORE** medical attention can be administered in a non-emergency situation. In order for us to communicate with your child's coach regarding any injury/illness incurred during athletic participation for their school, we must obtain written/verbal permission from the parent/guardian. By signing this release form, you are stating you have been advised of this right and are granting permission for employees of Piedmont Orthopaedic & Sports Medicine Complex (POSM) as well as the Athletic Therapy & Rehabilitation Institute (ATARI) to discuss any injury/illness sustained by your child during athletic participation with his/her coach.

A copy of the *Right of Privacy Act* is posted in our office. If you would like to receive a copy by mail, please contact our office at 478-474-0240.

Thank you in advance for your cooperation in this matter.

By affixing my signature below, I hereby give permission for POSM or ATARI to discuss any injury/illness my child incurred during athletic competition with his/her coach. Consent is given for the for the 20___-20________academic school year.

______________________________ ____

Printed name Signature Date

____

Relationship to patient

4660 RIVERSIDE PARK BLVD., MACON, GEORGIA 31210
(478) 474-2114 FAX (478) 474-8001 TOLL FREE 1-800-338-5141

RELEASE FOR TREATMENT
AT
PIEDMONT SPORTS MEDICINE

PATIENT INFORMATION

DATE ______________________

NAME ______________________

SCHOOL ______________________

HOME ADDRESS ______________________

SS# ______________________

____

PHONE# ______________________

____

PHONE# ______________________

PARENT INFORMATION

FATHER ______________________

ADDRESS ______________________

EMPLOYER ______________________

PHONE (HM) ____________ (C) ____________

MOTHER ______________________

ADDRESS ______________________

EMPLOYER ______________________

PHONE (HM) ____________ (C) ____________

INSURANCE INFORMATION

PRIMARY INSURANCE ______________________

ADDRESS ______________________

NAME OF PERSON WHO CARRIES INSURANCE ______________________

PLACE OF EMPLOYMENT ______________________

ADDRESS ______________________

SS# ______________________

CITY ______________________

SECONDARY INSURANCE

ADDRESS ______________________

NAME OF PERSON WHO CARRIES INSURANCE ______________________

PLACE OF EMPLOYMENT ______________________

ADDRESS ______________________

SS# ______________________

CITY ______________________

PLEASE ATTACH A COPY OF INSURANCE CARD TO THIS FORM (FRONT & BACK)

I GIVE PERMISSION FOR THE PHYSICIANS AT PIEDMONT SPORTS MEDICINE TO TREAT MY SON/DAUGHTER

____
PATIENT'S NAME

____
PARENT'S SIGNATURE

____
DATE

■ Preparticipation Physical Evaluation
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam ____________________

Name ____________________ Date of birth ____________________

Sex _______ Age _________ Grade ___________ School _______________ Sport(s) _______________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

____

____

____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ____________		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: ____________		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

____

____

____

____

____

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ____________________ Signature of parent/guardian ____________________ Date __________

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EVALUACIÓN FÍSICA – PRE-PARTICIPACIÓN

FORMULARIO DE HISTORIAL MÉDICO

(Nota: Este formulario debe ser rellenado por el paciente y padre/madre antes de ver al doctor. El doctor debe mantener este formulario en el expediente)

Fecha del examen ____
Nombre ____ Fecha de nacimiento ____________
Género ______ Edad ______ Grado _______ Escuela ______________________ Deporte(s) __________________

Medicamentos y Alergias: Por favor, indica todos los medicamentos con y sin receta médica y suplementos (herbales y nutricionales) que estás tomando actualmente

____
____
____

Tienes alergias ☐ Sí ☐ No Si la respuesta es sí, por favor identifica abajo la alergia específica.
☐ Medicamentos ☐ Polen ☐ Comida ☐ Picaduras de insecto

Explica abajo las preguntas respondidas con un "sí". Coloca en un círculo las preguntas cuya respuesta desconoces.

PREGUNTAS GENERALES	**Sí**	**No**
1. ¿Ha rehusado o limitado alguna vez un doctor tu participación en deportes por alguna razón?		
2. ¿Tienes actualmente alguna condición médica? Si es así, por favor identifícala abajo:		
☐ Asma ☐ Anemia ☐ Diabetes ☐ Infecciones		
Otro: ____		
3. ¿Has pasado alguna vez la noche en el hospital?		
4. ¿Has tenido cirugía alguna vez?		

PREGUNTAS SOBRE LA SALUD DE TU CORAZÓN	**Sí**	**No**
5. ¿Te has desmayado alguna vez o casi te has desmayado DURANTE o DESPUÉS de hacer ejercicio?		
6. ¿Has tenido alguna vez molestia, dolor, opresión, o presión en el pecho cuando haces ejercicio?		
7. ¿Se acelera alguna vez tu corazón o se salta latidos (latidos irregulares) cuando haces ejercicio?		
8. ¿Te ha dicho alguna vez un doctor que tienes un problema de corazón? Si es así, marca el que sea pertinente		
☐ Presión alta ☐ Un soplo en el corazón		
☐ Nivel alto de colesterol ☐ Una infección en el corazón		
☐ Enfermedad de Kawasaki ☐ Otro: ______________________________		
9. ¿Ha ordenado alguna vez un doctor una prueba de tu corazón? (Por ejemplo, ECG/EKG, ecocardiograma)		
10. ¿Te sientes mareado o te falta el aire más de lo esperado cuando haces ejercicio?		
11. ¿Has tenido alguna vez una convulsión inexplicable?		
12. ¿Te cansas más o te falta el aire con más rapidez que a tus amigos cuando haces ejercicio?		

PREGUNTAS SOBRE LA SALUD DEL CORAZÓN DE TU FAMILIA

13. ¿Has tenido algún familiar que ha fallecido a causa de problemas de corazón o que haya fallecido de forma inexplicable o inesperada antes de la edad de 50 años (incluyendo ahogo, accidente de tráfico inesperado, o síndrome de muerte súbita infantil)?
14. ¿Tiene alguien en tu familia cardiomiopatía hipertrófica, síndrome Marfan, cardiomiopatía arritmogénica ventricular derecha, síndrome de QT corto, síndrome de Brugada, o taquicardia ventricular polimórfica catecolaminérgica?
15. ¿Tiene alguien en su familia problemas de corazón, marcapasos, o desfibrilador implantado?
16. ¿Ha sufrido alguien en tu familia un desmayo inexplicable, convulsiones inexplicables, o casi se ha ahogado?

PREGUNTAS SOBRE HUESOS Y ARTICULACIONES	**Sí**	**No**
17. ¿Alguna vez has perdido un entrenamiento o partido porque te habías lesionado un hueso, músculo, ligamento o tendón?		
18. ¿Te has roto o fracturado alguna vez un hueso o dislocado una articulación?		
19. ¿Has sufrido alguna vez una lesión que haya requerido radiografías, IRM, escán de TC, inyecciones, terapia, un soporte ortopédico/tablilla, un yeso, o muletas?		
20. ¿Has sufrido alguna vez una fractura por estrés?		

21. ¿Te han dicho alguna vez que tienes o has tenido una radiografía para inestabilidad del cuello o inestabilidad atlantoaxial? (Síndrome de Down o enanismo)
22. ¿Usas regularmente una tabilla/soporte ortopédico, ortesis, u otro dispositivo de asistencia?
23. ¿Tienes una lesión en un hueso, músculo o articulación que te esté molestando?
24. ¿Algunas de tus articulaciones se vuelven dolorosas, inflamadas, se sienten calientes, o se ven enrojecidas?
25. ¿Tienes historial de artritis juvenil o enfermedad del tejido conectivo?

PREGUNTAS MÉDICAS **Sí** **No**
26. ¿Toses, tienes sibilancias o dificultad para respirar durante o después de hacer ejercicio?
27. ¿Has usado alguna vez un inhalador o has tomado medicamento para el asma?
28. ¿Hay alguien en tu familia que tenga asma?
29. ¿Naciste sin o te falta un riñón, un ojo, un testículo (varones), tu bazo, o algún otro órgano?
30. ¿Tienes dolor en la ingle o una protuberancia o hernia dolorosa en el área de la ingle?
31. ¿Has tenido mononucleosis (mono) infecciosa en el último mes?
32. ¿Tienes algún sarpullido, llagas de presión, u otros problemas en la piel?
33. ¿Has tenido herpes o infección de SARM en la piel?
34. ¿Has sufrido alguna vez una lesión o contusión en la cabeza?
35. ¿Has sufrido alguna vez un golpe en la cabeza que te haya producido una confusión, dolor de cabeza prolongado, o problemas de memoria?
36. ¿Tienes un historial de un trastorno de convulsiones?
37. ¿Tienes dolores de cabeza cuando haces ejercicio?
38. ¿Has tenido entumecimiento, hormigueo, o debilidad en los brazos o piernas después de haber sufrido un golpe o haberte caído?
39. ¿Has sido alguna vez incapaz de mover los brazos o las piernas después de haber sufrido un golpe o haberte caído?
40. ¿Te has enfermado alguna vez al hacer ejercicio cuando hace calor?
41. ¿Tienes calambres frecuentes en los músculos cuando haces ejercicio?
42. ¿Tienes tú o alguien en tu familia el rasgo depranocítico o la enfermedad drepanocítica?
43. ¿Has tenido algún problema con los ojos o la vista?
44. ¿Has sufrido alguna lesión o daño en los ojos?
45. ¿Usas lentes o lentes de contacto?
46. ¿Usas protección para los ojos, tal como lentes protectoras o un escudo facial?
47. ¿Te preocupa tu peso?
48. ¿Estás intentando aumentar o perder de peso o alguien te ha recomendado que lo hagas?
49. ¿Estás en una dieta especial o evitas ciertos tipos de comidas?
50. ¿Has tenido alguna vez un trastorno alimenticio?
51. ¿Tienes alguna preocupación de la que quieras hablar con el doctor?

SÓLO PARA MUJERES
52. ¿Has tenido alguna vez un período menstrual?
53. ¿Qué edad tenías cuando tuviste tu primer período menstrual?
54. ¿Cuántos períodos has tenido en los últimos 12 meses?

Explica aquí las preguntas a las que respondiste con un "sí"
____
____
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____
____
____

Yo por la presente declaro que, según mi más leal saber y entender, mis respuestas a las preguntas anteriores están completas y son correctas.

Firma del atleta ________________________________ **Firma del padre/madre/tutor legal** ____________________________ **Date** __________

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■ PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name ____ Date of birth ______________________

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports ______________________________________
  Reason ____

Recommendations ____

____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ______________________________________ Date ______________

Address ____ Phone ______________________

Signature of physician ____, MD or DO

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Preparticipation Physical Evaluation
CLEARANCE FORM

Name ______________________________ Sex ☐ M ☐ F Age __________ Date of birth __________

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports ______________________________

  Reason ______________________________

Recommendations ______________________________

____

____

____

____

____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ______________________________ Date __________

Address ______________________________ Phone __________

Signature of physician ______________________________, MD or DO

EMERGENCY INFORMATION

Allergies ______________________________

____

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____

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Other information ______________________________

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Preparticipation Physical Evaluation

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam ____________________

Name ____________________ Date of birth ____________________

Sex ________ Age __________ Grade ____________ School ____________________ Sport(s) ____________________

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

____

____

____

____

____

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

____

____

____

____

____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete ____________________ Signature of parent/guardian ____________________ Date ____________

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