

PIKE COUNTY HIGH SCHOOL  
PIKE COUNTY MIDDLE SCHOOL  
ZEBULON, GA

I/We, the undersigned parent(s) and/or guardian(s) of hereby grant permission for my student,

\_\_\_\_\_, \_\_\_\_\_, to participate in (Sport/Activity) \_\_\_\_\_ for the  
(PRINT Last Name) (PRINT First Name)

For the 20\_\_\_\_ - 20\_\_\_\_ school year.

\*\* I/We understand that if any injury occurs to my student during practice/game/performance that I/We are responsible for filing an accident report with the staff supervisor.

\*\* I/We understand that I/We are responsible for filing school insurance within 90 days of the injury.

\*\* I/We have been made aware of procedures that will be in place to provide safeguards to staff and students related to COVID-19. I/We confirm that we are comfortable with the articulated procedures and the risks associated with my student's participation in this activity.

\*\* I/We understand that Georgia High School Association Governs Athletic Eligibility for students participating in any athletic competition as follows:

- 9th Graders: All incoming 9th grade students are eligible to participate first semester. (must pass 5 classes to be eligible second semester)
- 10th, 11th, 12th graders: must have passed 5 classes the semester prior to participation and earned the minimum number of credits going into each grade (10<sup>th</sup>=5, 11<sup>th</sup>=11, 12<sup>th</sup>=17).
- Any credit gained through credit recovery, must be recovered within the first ten days of the semester.
- All Student Athletes must adhere to the Extra Curricular Code of Conduct.

\_\_\_\_\_  
(PRINT Parent/Guardian Last Name)

\_\_\_\_\_  
(PRINT Parent/Guardian First Name)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

PIKE COUNTY SCHOOL SYSTEM  
AUTHORIZATION TO CARRY STUDENT TO HOSPITAL

I hereby authorize \_\_\_\_\_ to take my child to the hospital emergency room for treatment. I understand that I am legally responsible for any financial obligations incurred in the emergency treatment of my child.

\_\_\_\_\_  
Name of Student

\_\_\_\_\_  
Name of Parent/Guardian

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date

AUTHORIZATION FOR THIRD PARTY TO CONSENT TO TREATMENT OF MINOR  
LACKING CAPACITY TO CONSENT

I/We, the undersigned, parent(s)/person having legal custody/legal guardianship of \_\_\_\_\_, a minor, do hereby authorize \_\_\_\_\_ as agent(s) for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon duly licensed, whether such diagnosis or treatment is rendered at the office of said physician or at the hospital.

These authorizations shall remain effective until \_\_\_\_\_, 20\_\_\_\_

Unless sooner revoked in writing delivered to said agent(s).

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Student Social Security Number

\_\_\_\_\_  
Student's Date of Birth

\_\_\_\_\_  
Parent(s)/Guardian Name

\_\_\_\_\_  
Permanent Address (Street, PO Box, City, Zip)

\_\_\_\_\_  
Area Code + Home Phone

\_\_\_\_\_  
Area Code + Work Phone (Parent)

\_\_\_\_\_  
Emergency Contact

\_\_\_\_\_  
Area Code + Emergency Contact Phone

\_\_\_\_\_  
Insurance Carrier

\_\_\_\_\_  
Policy Number

## **Student athletes must be academically eligible to participate.**

1- Students must accumulate units towards graduation according to the following criteria:

- (a) First-year students (entering 9th grade) are eligible academically. Second semester first-year students must have passed courses carrying at least 2.5 units the previous semester in order to participate.
- (b) Second-year students must have accumulated five (5) total units in the first year, AND passed courses carrying at least 2.5 units in the previous semester.
- (c) Third-year students must have accumulated eleven (11) units in the first and second years, AND passed courses carrying at least 2.5 units in the previous semester.
- (d) Fourth-year students must have accumulated seventeen (17) units in the first three years, AND passed courses carrying at least 2.5 units in the previous semester.

2- Students must be enrolled in 2.5 credit hours in the current semester to participate.

- (a) Option B (formally known as Senate Bill 2) students must be enrolled in 2.5 credit hours.
- (b) Dual enrollment students must be enrolled in 2.5 credit hours.





## Parent Release Form For Student Athlete Over the Counter Medication

I, \_\_\_\_\_ (Parent's/Guardian's Name Printed), give consent for the Athletic Trainer at Pike County High School to provide \_\_\_\_\_ (Athlete's Name Printed) over the counter medications such as Tylenol, Ibuprofen, Aspirin, Electrolyte/Glucose Supplements, or Heartburn medication in the event it is deemed appropriate. The athletic trainer reserves the judgement to refuse the administration of the medications listed above if a concussion of the athlete is suspected. By signing this form, you, the Parent/Guardian, give consent and forfeit any future action against the Pike County Board of Education, Pike County School System, Pike County Coaches, and Athletic Trainer in the event that the student athlete experiences any adverse side effects.

\_\_\_\_\_ (Parent Signature) Date: \_\_\_\_\_

\_\_\_\_\_ (Student Signature) Date: \_\_\_\_\_

### PIKE COUNTY SCHOOLS

www.pike.k12.ga.us  
16 Jackson Street  
Zebulon, Georgia 30295  
O: (770) 567 - 8489



# Georgia High School Association

## Student/ Parent Sudden Cardiac Arrest Awareness Form

SCHOOL: PIKE COUNTY HIGH SCHOOL

### 1: Learn the Early Warning Signs

If you or your child has had one or more of these signs, see your primary care physician:

- Fainting suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks or ringing phones
- Unusual chest pain or shortness of breath during exercise
- Family members who had sudden, unexplained and unexpected death before age 50
- Family members who have been diagnosed with a condition that can cause sudden cardiac death, such as hypertrophic cardiomyopathy (HCM) or Long QT syndrome
- A seizure suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks or ringing phones

### 2: Learn to Recognize Sudden Cardiac Arrest

If you see someone collapse, assume he has experienced sudden cardiac arrest and respond quickly. This victim will be unresponsive, gasping or not breathing normally, and may have some jerking (Seizure like activity). Send for help and start CPR. You cannot hurt him.

### 3: Learn Hands-Only CPR

Effective CPR saves lives by circulating blood to the brain and other vital organs until rescue teams arrive. It is one of the most important life skills you can learn – and it's easier than ever.

- Call 911 (or ask bystanders to call 911 and get an AED)
- Push hard and fast in the center of the chest. Kneel at the victim's side, place your hands on the lower half of the breastbone, one on top of the other, elbows straight and locked. Push down 2 inches, then up 2 inches, at a rate of 100 times/minute, to the beat of the song "Stayin' Alive."
- If an Automated External Defibrillator (AED) is available, open it and follow the voice prompts. It will lead you step-by-step through the process, and will never shock a victim that does not need a shock.

By signing this sudden cardiac arrest form, I give PIKE COUNTY High School permission to transfer this sudden cardiac arrest form to the other sports that my child may play. I am aware of the dangers of sudden cardiac arrest and this signed sudden cardiac arrest form will represent myself and my child during the 20\_\_\_\_-20\_\_\_\_ school year. This form will be stored with the athletic physical form and other accompanying forms required by the \_\_\_\_\_ School System.

**I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.**

\_\_\_\_\_  
Student Name (Printed)

\_\_\_\_\_  
Student Name (Signed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Name (Printed)

\_\_\_\_\_  
Parent Name (Signed)

\_\_\_\_\_  
Date

(Revised: 4/22)

# Georgia High School Association Student/Parent Concussion Awareness Form

SCHOOL: PIKE COUNTY HIGH SCHOOL

## DANGERS OF CONCUSSION

Concussions at all levels of sports have received a great deal of attention and a state law has been passed to address this issue. Adolescent athletes are particularly vulnerable to the effects of concussion. Once considered little more than a minor "ding" to the head, it is now understood that a concussion has the potential to result in death, or changes in brain function (either short-term or long-term). A concussion is a brain injury that results in a temporary disruption of normal brain function. A concussion occurs when the brain is violently rocked back and forth or twisted inside the skull as a result of a blow to the head or body. Continued participation in any sport following a concussion can lead to worsening concussion symptoms, as well as increased risk for further injury to the brain, and even death.

Player and parental education in this area is crucial – that is the reason for this document. Refer to it regularly. This form must be signed by a parent or guardian of each student who wishes to participate in GHSA athletics. One copy needs to be returned to the school, and one retained at home.

## COMMON SIGNS AND SYMPTOMS OF CONCUSSION

- Headache, dizziness, poor balance, moves clumsily, reduced energy level/tiredness
- Nausea or vomiting
- Blurred vision, sensitivity to light and sounds
- Fogginess of memory, difficulty concentrating, slowed thought processes, confused about surroundings or game assignments
- Unexplained changes in behavior and personality
- Loss of consciousness (NOTE: This does not occur in all concussion episodes.)

**BY-LAW 2.68: GHSA CONCUSSION POLICY:** In accordance with Georgia law and national playing rules published by the National Federation of State High School Associations, any athlete who exhibits signs, symptoms, or behaviors consistent with a concussion shall be immediately removed from the practice or contest and shall not return to play until an appropriate health care professional has determined that no concussion has occurred. (NOTE: An appropriate health care professional may include licensed physician (MD/DO) or another licensed individual under the supervision of a licensed physician, such as a nurse practitioner, physician assistant, or certified athletic trainer who has received training in concussion evaluation and management.

a) No athlete is allowed to return to a game or a practice on the same day that a concussion (a) has been diagnosed, OR (b) cannot be ruled out.

b) Any athlete diagnosed with a concussion shall be cleared medically by an appropriate health care professional prior to resuming participation in any future practice or contest. The formulation of a gradual return to play protocol shall be a part of the medical clearance.

By signing this concussion form, I give PIKE COUNTY High School permission to transfer this concussion form to the other sports that my child may play. I am aware of the dangers of concussion and this signed concussion form will represent myself and my child during the 20\_\_\_\_-20\_\_\_\_ school year. This form will be stored with the athletic physical form and other accompanying forms required by the \_\_\_\_\_ School System.

**I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.**

\_\_\_\_\_  
Student Name (Printed)

\_\_\_\_\_  
Student Name (Signed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Name (Printed)

\_\_\_\_\_  
Parent Name (Signed)

\_\_\_\_\_  
Date

(Revised: 4/22)



## Community Acquired Methicillin Resistant Staphylococcus Aureus (CA-MRSA)

According to the Centers for Disease Control and Prevention, participants in competitive sports are at risk for skin infections because of physical contact, skin damage, and sharing of equipment. Humid, crowded conditions such as those found in locker rooms and gyms provide a good place for Staphylococcus Aureus (Staph) to grow. The following will provide the student and parent with practical information:

- Staph is commonly carried in nasal passages, under fingernails, or on the skin without any medical problems. It can enter the body from a cut, insect bite, or surgical incision. Normally a minor infection occurs. However, if a person has a weakened immune system from an illness, the infection could become more serious.
  - Prevention involves players, coaches, parents, and the school. The following practices are recommended to parents of students when the conditions warrant:
    - The student should wash hands thoroughly with soap and water during the day. Waterless hand cleanser can be used.
    - The student should practice good hygiene to include showering/bathing with soap and water after all practices and competitions. Previously worn protective clothing can be hot and cause chafing which results in broken skin. Skin trauma from turf or mat burns are other risk factors.
    - Use liquid soap in showers instead of sharing bar soaps; sharing can spread bacteria to other family members. Shower as soon as possible after practice/working out/competitions.
    - It is suggested to wash towels after each use and avoid sharing bed liners, razors, and other personal items.
    - The student should not store or wear previously worn wet clothing. Wet or damp clothing/equipment is a breeding ground for bacteria and fungus.
    - The student will cover all open wounds. If a wound cannot be covered, there is a possibility that the student will need to be excluded from practice/ workout/ competition until the wound heals.
    - Students should report skin lesions to the parent as well as the coach. Parents and coaches will check a lesion that is potentially infected.
    - The student and parents should understand the importance of seeking medical attention at the first sign of infection. Early signs are redness and swelling of the affected area, pain, drainage (pus) around the area of an insect bite, cut or abrasion.
    - If medication is prescribed by a physician, the student should take the entire amount of medication in the prescribed amount of time. Follow school rules regarding medicine on campus.
    - The student should avoid getting into a hot tub or whirlpool until all wounds are healed.
- Information obtained from the Centers for Disease Control and Prevention and State Epidemiologist Cristina Pasa. For more information visit the Centers for Disease Control and Prevention website.

2.67 Practice Policy for Heat and Humidity:

- (a) Schools must follow the statewide policy for conducting practices and voluntary conditioning workouts (this policy is year-round, including during the summer) in all sports during times of extremely high heat and/or humidity that will be signed by each head coach at the beginning of each season and distributed to all players and their parents or guardians. The policy shall follow modified guidelines of the American College of Sports Medicine in regard to:
  - (1) The scheduling of practices at various heat/humidity levels.
  - (2) The ratio of workout time to time allotted for rest and hydration at various heat/humidity levels.
  - (3) The heat/humidity levels that will result in practice being terminated.
- (b) A scientifically-approved instrument that measures the Wet Bulb Globe Temperature must be utilized at each practice to ensure that the written policy is being followed properly. WBGT readings should be taken every hour, beginning 30 minutes before the beginning of practice.

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**WBGT      ACTIVITY GUIDELINES AND REST BREAK GUIDELINES**

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Under 82.0	Normal Activities - Provide at least three separate rest breaks each hour with a minimum duration of 3 minutes each during the workout.
82.0 - 86.9	Use discretion for intense or prolonged exercise; watch at-risk players carefully. Provide at least three separate rest breaks each hour with a minimum duration of 4 minutes each.
87.0 - 89.9	Maximum practice time is 2 hours. <u>For Football:</u> players are restricted to helmet, shoulder pads, and shorts during practice, and all protective equipment must be removed during conditioning activities. If the WBGT rises to this level during practice, players may continue to work out wearing football pants without changing to shorts. <u>For All Sports:</u> Provide at least four separate rest breaks each hour with a minimum duration of 4 minutes each.
90.0 - 92.0	Maximum practice time is 1 hour. <u>For Football:</u> no protective equipment may be worn during practice, and there may be no conditioning activities. <u>For All Sports:</u> There must be 20 minutes of rest breaks distributed throughout the hour of practice.
Over 92.0	No outdoor workouts. Delay practice until a cooler WBGT level is reached.

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- (c) Practices are defined as: the period of time that a participant engages in a coach-supervised, school-approved sport or conditioning-related activity. Practices are timed from the time the players report to the practice or workout area until players leave that area. If a practice is interrupted for a weather-related reason, the "clock" on that practice will stop and will begin again when the practice resumes.
- (d) Conditioning activities include such things as weight training, wind-sprints, timed runs for distance, etc., and may be a part of the practice time or included in "voluntary workouts."
- (e) A walk-through is not a part of the practice time regulation, and may last no longer than one hour. This activity may not include conditioning activities or contact drills. No protective equipment may be worn during a walk-through, and no full-speed drills may be held.
- (f) Rest breaks may not be combined with any other type of activity and players must be given unlimited access to hydration. These breaks must be held in a "cool zone" where players are out of direct sunlight.

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
(First Name) (Last Name)

Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Sex assigned at birth: \_\_\_\_\_

List past and current medical conditions. \_\_\_\_\_

Have you ever had surgery? If yes, list all past surgical procedures. \_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). \_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). \_\_\_\_\_

Patient Health Questionnaire Version 4 (PHQ-4)  
*Over the last 2 weeks, how often have you been bothered by any of the following problems? (check box next to appropriate number)*

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

(First Name)

(Last Name)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)			Yes	No
1. Do you have any concerns that you would like to discuss with your provider?				
2. Has a provider ever denied or restricted your participation in sports for any reason?				
3. Do you have any ongoing medical issues or recent illness?				
HEART HEALTH QUESTIONS ABOUT YOU			Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?				
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?				
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?				
7. Has a doctor ever told you that you have any heart problems?				
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.				

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)			Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?				
10. Have you ever had a seizure?				
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY			Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?				
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?				
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?				



## ■ PREPARTICIPATION PHYSICAL EVALUATION

### PHYSICAL EXAMINATION FORM

Name: \_\_\_\_\_ (First Name) \_\_\_\_\_ (Last Name) Date of birth: \_\_\_\_\_

#### PHYSICIAN REMINDERS

- 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, e-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-enhancing 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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height:	Weight:	
BP: / ( / )	Pulse:	Vision: R 20/ L 20/ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul>		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>		
Lymph nodes		
Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> <li>Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis</li> </ul>		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional <ul style="list-style-type: none"> <li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>		

<sup>a</sup> Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### MEDICAL ELIGIBILITY FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Medically eligible for all sports without restriction

Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

\_\_\_\_\_

Medically eligible for certain sports

\_\_\_\_\_

Not medically eligible pending further evaluation

Not medically eligible for any sports

Recommendations: \_\_\_\_\_

\_\_\_\_\_

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

### SHARED EMERGENCY INFORMATION

Allergies: \_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

Other information: \_\_\_\_\_

\_\_\_\_\_

Emergency contacts: \_\_\_\_\_

\_\_\_\_\_