Dear Parent or Guardian:

ANY student who is interested in participating in our varsity athletic program MUST have a physical on file in the athletic office before they will be allowed to participate in any official practice or game.

This physical is not the same as a regular physical exam administered by our family physician. It is a screening to ensure that your child is medically eligible for participation in accordance with our association's guidelines. Memorial Day School recommends that every child receive a regular physical exam from his / her primary care physician to ensure general good health.

You will notice 11 pages attached. Please follow the instructions carefully as listed below:

[ 1 ] MEMORIAL DAY SCHOOL <> PLAYER – PARENT CONTRACT

[ 2 ] PARENT / STUDENT-ATHLETE COMMITMENT FORM

[ 3 ] PERMISSION & MEDICAL RELEASE FORM
Fill out this form and have it signed in three (3) places by both the athlete and the parent / guardian.

[ 4 ] EMERGENCY CONTACT & INSURANCE INFORMATION
This form is important should an emergency arise. Please fill this page out completely.

[ 5-6 ] PREPARTICIPATION PHYSICAL EVALUATION <> HISTORY FORM
This form must be completed and signed by both the athlete and parent / guardian.

[ 7 ] PREPARTICIPATION PHYSICAL EVALUATION <> PHYSICAL EXAMINATION FORM
This is one form that must be completed and signed by the examining physician.

[ 8 ] PREPARTICIPATION PHYSICAL EVALUATION <> CLEARANCE FORM
This is the other form that must be completed and signed by the examining physician.

[ 9-11 ] CONCUSSION MANAGEMENT AND RETURN TO PLAY POLICY
This should be read by both the player and the parents and signed by both.

When all of these forms are completed, please return them to your athlete's coach or the school office.

Thank you for your cooperation.

TYLER HELMLY
Athletic Director
MEMORIAL DAY SCHOOL <> PLAYER – PARENT CONTRACT

It is important to the administration and the athletic coaching staff of Memorial Day School that our teams develop, displays and promotes professionalism at all times. Therefore, standards and expectations have been established to help student-athletes stay focused on goals. Each team’s coaching staff will develop and implement rules and consequences hold their team members accountable.

All student-athletes and their parents are asked to sign this Player – Parent Contract confirming their acknowledgement, understanding and support of our expectations, rules and consequences for noncompliance.

I. PLAYER EXPECTATIONS:
A. Punctuality. BE EARLY to dress, socialize and stretch. Time posted is the time PRACTICE BEGINS.
B. WORK HARD – and expect HARD WORK to be asked of you.
C. Display and maintain a POSITIVE ATTITUDE at all times.
D. Dedicate yourself to learning and/or improving a skill EVERY DAY.
E. Place the TEAM’S goals ahead of your own personal goals. (ALTRUISTIC vs. EGOCENTRIC)
F. Our schedule will not be easy. RESPECT all – but FEAR none
G. This team is a FAMILY. ENCOURAGE your teammates. Do not tear them down on the field, at school, when you away from them or online.
H. Discuss any questions or concerns with your coach in a positive and mature manner.
I. As an athlete, you are expected to take care of your bodies. This includes proper nutrition, stretching, conditioning, as well as refraining from risky substances or activities.

J. Remember your priorities: Faith, Family, Academics, Team and other activities.

II. PARENT EXPECTATIONS:
A. RELINQUISH your coaching responsibilities. Allow the coaches to do their job.
B. Promote LOYALTY and TRUST towards the program’s mission and coaches.
C. Place the TEAM’S goals ahead of your own personal goals. (ALTRUISTIC vs. EGOCENTRIC)
D. Practice mutual RESPECT and SUPPORT with the coaches.
E. REPRESENT this program appropriately on the field, in the stands and in the community.
F. Be active in fundraising and teambuilding events.
G. Please DO NOT ATTEND practices or workouts.
H. NEVER CONFRONT a coach regarding any matter before or after a practice or game.
I. Topics NOT OPEN TO DISCUSSION with coaches:
   1. Playing Time
   2. Team Strategy
   3. Play Calling
J. If any conflicts or concerns arise, they are to be resolved via the following procedure:
   1. STEP 1 – Player should approach the immediate coach and schedule a time to discuss question or concern. If player does not feel comfortable and satisfied with the outcome of this meeting, proceed to Step 2.
   2. STEP 2 – Player should request a meeting with his or her self, the coach and the head coach. If player does not feel comfortable and satisfied with the outcome of this meeting, proceed to Step 3.
   3. STEP 3 – A meeting of the player, coaches and parents of the player should be requested via E-Mail to the Head Coach. If meeting does not resolve the situation, the player and parent should proceed to Step 4.
   4. STEP 4 - A meeting of the player, coaches, parents of the player and Athletic Director should be requested via E-Mail to the Athletic Director (and copied to all included parties). If all parties are still not comfortable with the situation, a meeting including additional levels of administration should be requested to discuss an alternative solution.

I, ____________________________________________, upon signing this team contract, hereby promise to do my best in thought, word and deed and to commit myself to the mission and goals of the Memorial Day School Athletic Program. I am aware that any behavior that portrays a negative perception of me or my team could be reviewed by the coaching staff and administration for possible on-field penalties, suspension or dismissal from the team.

Player Signature ____________________________________________ Date ____________________

Parent Signature ____________________________________________ Date ____________________

Parent email address ____________________________________________

Parent contact phone number ____________________________________________

PHYSICAL PACKAGE PAGE 1
Dear Parents and Student-Athletes:

We are pleased that your student athlete has the opportunity to participate in athletics at Memorial Day School. We feel it is very important to share some basic guidelines regarding the commitment both you and your student-athlete are about to make and thereby, have your support throughout the season(s).

We hope you have considered both the benefits and constraints involved in being a team member. Each athletic season consists of weeks of practices, games and travel. Our coaching staff will make every effort to plan and organize the entire season and we will advise you of practice times, game dates and travel arrangements.

We have listed items below that each parent and student-athlete need to be aware of. It is the parent’s and athlete’s responsibility to become aware of the commitment, rules and regulations of being on an athletic team.

1. Be certain your student-athlete is committed to participating at this level of competition and is willing to give the time and effort both at practices and games throughout the entire season.
2. Consider the time spent on sports and the impact on your family as well as on study time. Also consider other activities in your life that will be impacted such as church activities, other sports teams and other school involvement. Your student-athlete will be expected to attend and participate in all practices and all games including those scheduled during school holidays. The team needs and must have your commitment to be successful.
3. Realize that there is potential for injury in any sport. Your medical coverage should be up-to-date before the season begins.
4. Be cognizant of the coach’s requirements and expectations so you can better understand his / her methods and emphasis.
5. Parents, consider and discuss with your student athlete that their conduct should reflect and reinforce the values and rules of our school. These rules will be enforced not just during the school day, but at all athletic events.
6. Evaluate the financial cost for participation on the team.
7. As a parent, be willing to support the team in whatever way you can (i.e. refreshments, encouragement, attendance at contests, etc.)
8. Realize to quit a team is something the coaches and the athletic department heartily discourage and should not be done without considering the ramifications. Student-Athletes who make the commitment to play for one of our Varsity teams, only to quit before the end of the season (playoffs included), may be denied joining any other Varsity team.

My signature below indicates that I have read this document and have discussed it with my student athlete.

_________________________________________  _________________
Parent/Guardian Signature          Date

_________________________________________  _________________
Parent/Guardian Signature          Date

_________________________________________  _________________
Student-Athlete Signature          Date
MEMORIAL DAY SCHOOL
PERMISSION & MEDICAL RELEASE FORM

ATHLETE’S LAST NAME: ___________________________ FIRST NAME: ___________________________ MI: __________

ASSUMPTION OF RISK

I am aware playing or practicing to play / participate in any sport or sport related activity could be a dangerous activity involving MANY RISKS OF INJURY. I understand that the dangers and risks of playing or practicing to play / participate in sports or sport related activity include, but are not limited to: death; serious neck and spinal injuries that may result in complete or partial paralysis; brain damage; serious injury to virtually all bones, joints, ligaments, muscles, tendons, other aspects of the musculoskeletal system and vital organs; and serious impairment to other aspects of the body, general health, and well-being. I understand the dangers and risks of playing or practicing to play / participate in any sport or sport related activity may result not only in serious injury, but in a serious impairment of my (the participant’s) future abilities to earn a living; to engage in other business, social and recreational activities; and generally enjoy life. Because of the dangers of playing or practicing to play / participate in any sport or sport related activity, I recognize the importance of following the coach’s, official’s and medical staff’s instructions regarding playing techniques, training, and other team rules, etc., and agree to obey such instructions.

As the parent / legal guardian of the above named participant, I have read the above warnings and release, and understand its terms. I hereby agree to hold Memorial Day School, its direct and contracted employees, agents, representatives, coaches and volunteers, harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever that may arise by or in connection with participation of my child in any activities related to Memorial Day School activities. The terms hereof will serve as a release for my heirs, estate, executor, administrator, assignees, and for all members of my family. Whenever injury and / or sickness occur to the participant listed above, and the participant is under the supervision of Memorial Day School, and the participant’s parent / legal guardian is unavailable to give his / her permission for treatment, the participant and others whose signatures are attached below do hereby give permission to authorize any emergency action necessary to ensure the safety of the child. The intention hereof being to grant authority to administer and perform all and singularly any examinations, pre-participation physical examinations, treatments, anesthetics, operations, and diagnostic procedures which may now, or during the course of this participant’s care, be deemed advisable or necessary. This does not hold Memorial Day School financially responsible for any medical care given.

I specifically acknowledge that Football, Soccer, and Wrestling are collision sports that involve an even greater risk of injury than contact sports: Basketball, Baseball, Cheerleading, Softball, and Volleyball which involve greater risk of injury than non-contact sports: Track & Field, Tennis, Cross Country, Rowing and Golf.

PARTICIPANT’S SIGNATURE ___________________________ DATE ______/______/______ PARENT / GUARDIAN SIGNATURE ___________________________ DATE ______/______/______

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

GENERAL DISCLOSURE

I hereby authorize medical personnel to release information from my medical records for the purpose of payment, treatment or operations to their business associate partner which includes: the attending school’s coaching staff and administrators; and any hospital in case of an emergency situation. This authorization shall be valid for the duration of the school year. It is subject to revocation by the patient, or the parent / guardian at any time except to the extent that action has been taken in reliance thereon. I am aware that once Memorial Day School discloses this information per my instructions, the information is subject to re-disclosure and may no longer be protected by the HIPAA (Health Insurance Portability and Accountability Act) of 1996. I understand that a photocopy of this authorization shall be as valid as the original. I know that I, or my authorized representative may receive a copy of this authorization upon request.

PARTICIPANT’S SIGNATURE ___________________________ DATE ______/______/______ PARENT / GUARDIAN SIGNATURE ___________________________ DATE ______/______/______

If the athlete is physically unable to sign, please indicate such and identify the authority of the person to act who is signing for the athlete:

DISCLOSURE REQUIRING SPECIAL CONSENT

My signature below specifically authorizes the release of health care information relating to the testing, diagnosis, or treatment for (please check all that you wish released):

<table>
<thead>
<tr>
<th>HIV / AIDS Virus</th>
<th>Mental Health / Psychiatric Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If treatment is rendered for HIV / AIDS, Hepatitis, Psychiatric and / or alcohol / drug abuse, this release will be restricted to a one-time release of information only:

PARTICIPANT’S SIGNATURE ___________________________ DATE ______/______/______ PARENT / GUARDIAN SIGNATURE ___________________________ DATE ______/______/______

If the athlete is physically unable to sign, please indicate such and identify the authority of the person to act who is signing for the athlete:

THE LOGO

PHYSICAL PACKAGE PAGE 3
MEMORIAL DAY SCHOOL

EMERGENCY CONTACT & INSURANCE INFORMATION

STUDENT’S LEGAL NAME: ___________________________________________________ ______________________ __________

LAST NAME           FIRST NAME                MI

SOCIAL SECURITY NO: _______________ - _______________ - _______________ DATE OF BIRTH: _____ / _____ / ______

CLASS LEVEL / CURRENT GRADE: ______

ADDRESS: _____________________________________________ _______________________ __________ ________________

STREET ADDRESS             CITY    STATE          ZIP CODE

PARENT / GUARDIAN NAME: _________________________________________________________________

HOME PHONE NUMBER: (     ) __________ - _____________ CELL PHONE:  (     ) __________ - _____________

PARENT / GUARDIAN EMPLOYER: _____________________________________________________________

PARENT / GUARDIAN WORK PHONE NUMBER: (     ) __________ - _____________

IN CASE OF EMERGENCY, PLEASE CONTACT ( MUST BE 21 YEARS OF AGE OR OLDER ):

NAME: ______________________________________________________  RELATIONSHIP : _______________________________

CONTACT PHONE NUMBER: (     ) __________ - _____________ / OR / (     ) __________ - _____________

PRIMARY PHYSICIAN: __________________________________________ PHONE: (     ) __________ - _____________

**** PLEASE BE AWARE OF THE FOLLOWING WHEN CARING FOR MY CHILD ****

MEDICAL CONDITIONS: ______________________________________________________________________________________

________________________________________________________________________________________________________

ALLERGIES: ________________________________________________________________________________________________

MEDICATIONS & CONDITIONS: ________________________________________________________________________________

INSURANCE INFORMATION

INSURANCE COMPANY: __________________________________________________

NAME OF POLICY HOLDER: ____________________________________________ POLICY NO. __________________________

INSURANCE COMPANY PHONE NO. (     ) _____________ - _____________________

AND / OR

INSURANCE COMPANY: __________________________________________________

NAME OF POLICY HOLDER: ____________________________________________ POLICY NO. __________________________

INSURANCE COMPANY PHONE NO. (     ) _____________ - _____________________
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 below:

__________________________________________________________________________________

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

1. Has a doctor ever denied or restricted your participation in sports for any reason? 
   - Yes 
   - No

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?
   - Yes 
   - No

4. Have you ever had surgery?
   - Yes 
   - No

5. Have you ever passed out or nearly passed out DURING or AFTER exercise?
   - Yes 
   - No

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?
   - Yes 
   - No

7. Does your heart ever race or skip beats (irregular beats) during exercise?
   - Yes 
   - No

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)
   - Yes 
   - No

10. Do you get lightheaded or feel more short of breath than expected during exercise?
    - Yes 
    - No

11. Have you ever had an unexplained seizure?
    - Yes 
    - No

12. Do you get more tired or short of breath more quickly than your friends during exercise?
    - Yes 
    - No

### HEART HEALTH QUESTIONS ABOUT YOU

13. Do you have any history of juvenile arthritis or connective tissue disease?
    - Yes 
    - No

14. Do you regularly use a brace, orthotics, or other assistive device?
    - Yes 
    - No

15. 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)
    - Yes 
    - No

16. Have you ever had any broken or fractured bones or dislocated joints?
    - Yes 
    - No

17. Have you ever had surgery?
    - Yes 
    - No

18. Have you ever had a bone, muscle, or joint injury that bothers you?
    - Yes 
    - No

19. Do you regularly use protective eyewear, such as goggles or a face shield?
    - Yes 
    - No

20. Have you ever had a head injury or concussion?
    - Yes 
    - No

21. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

22. Have you ever had a heart murmur? 
    - Yes 
    - No

23. Have you ever been told that you have a heart murmur?
    - Yes 
    - No

24. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
    - Yes 
    - No

25. Has anyone in your family had unexplained fainting, unexplained car accident, or sudden infant death syndrome? (SIDS), or near drowning?
    - Yes 
    - No

26. Do you have any other family members or relatives who have had or have had heart disease?
    - Yes 
    - No

27. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?
    - Yes 
    - No

28. Have you ever had surgery?
    - Yes 
    - No

29. Do you or someone in your family have sickle cell trait or disease?
    - Yes 
    - No

30. Have you ever had surgery?
    - Yes 
    - No

31. Have you ever used an inhaler or taken asthma medicine?
    - Yes 
    - No

32. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

33. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

34. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

36. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

37. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

38. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

39. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

40. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

41. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

42. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

43. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

44. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

45. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

46. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

47. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

48. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

49. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

50. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

51. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

52. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

53. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

54. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
    - Yes 
    - No

### MEDICAL QUESTIONS

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>26. Have you ever used an inhaler or taken asthma medicine?</td>
<td></td>
</tr>
<tr>
<td>27. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>28. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>29. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>30. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>31. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>32. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>33. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>34. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>36. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>37. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>38. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>39. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>40. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>41. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>42. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>43. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>44. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>45. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>46. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>47. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>48. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>49. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>50. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
</tbody>
</table>

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 ________________

# Preparticipation Physical Evaluation

## THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam ____________________________________________________________

Name ____________________________________________________________ Date of birth __________

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Grade</th>
<th>School</th>
<th>Sport(s)</th>
</tr>
</thead>
</table>

### 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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

### 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.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

- 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 ________________

**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**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>( / )</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>R 20/</td>
<td>L 20/</td>
<td>Corrected</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical</th>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td></td>
<td>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</td>
</tr>
<tr>
<td>Eyes/ears/nose/throat</td>
<td></td>
<td>Pupils equal</td>
</tr>
<tr>
<td>Lymph nodes</td>
<td></td>
<td>Location of point of maximal impulse (PMI)</td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td>Murmurs (auscultation standing, supine, +/- Valsalva)</td>
</tr>
<tr>
<td>Pulses</td>
<td></td>
<td>Simultaneous femoral and radial pulses</td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitourinary (males only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td>HSV, lesions suggestive of MRSA, tinea corporis</td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Musculoskeletal**

<table>
<thead>
<tr>
<th>Neck</th>
<th>Back</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder/arm</td>
<td>Elbow/forearm</td>
</tr>
<tr>
<td>Wrist/hand/fingers</td>
<td>Hip/thigh</td>
</tr>
<tr>
<td>Knee</td>
<td>Leg/ankle</td>
</tr>
<tr>
<td>Foot/toes</td>
<td>Functional</td>
</tr>
<tr>
<td>Duck-walk, single leg hop</td>
<td></td>
</tr>
</tbody>
</table>

- Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
- Consider MRI if in private setting. Having third party present is recommended.
- 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
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 __________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

Other information __________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

______________________________________________________________________________________________________________

Physician's Note

□ Preparticipation Physical Evaluation Clearance Form

□ Physical Education Participation Form

□ Medical Transportation Authorization Form

□ Asthma Action Plan

□ Medical Emergency Plan

□ Individualized Education Plan (IEP)

□ 504 Plan

□ Other: ____________________
All Georgia Independent School Association Interscholastic Member Schools are required to comply with the following policy effective September 1, 2013. This policy applies to all practices, conditioning, and games in all sports. This policy will be reviewed by the Board of Trustees yearly, at which time comments and suggestions for the improvement of the policy will be solicited from all Member Schools, coaches, trainers, and officials, and appropriate modifications made.

I. Definitions.

A. “Health Care Provider” means a licensed physician 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.

B. “Student Athlete” means any student who participates in interscholastic athletic competitions at a Member School regardless of age.

C. “Coach” means all coaches of all interscholastic sports whether full or part time and whether paid or volunteer.

D. “Member School” means each Georgia Independent School Association Interscholastic Member School.

II. Policy.

A. At the beginning of every school year, all Member Schools shall provide to the parents or legal guardians of every Student Athlete an information sheet which informs them of the nature and risks of concussions and head injuries and the actions to be taken by the schools to minimize the risks and effects of concussions and head injuries. Such information sheet should be substantially in the form of Appendix A to this Policy, and each Member School shall maintain a copy of the information sheet signed by each Student Athlete’s parents or legal guardians for that school year.

B. If a Coach observes a Student Athlete exhibit any sign, symptom, or behavior consistent with a concussion or head injury, the Coach must immediately remove that Student Athlete from practice, conditioning, or game. The Student Athlete may not return to practice, conditioning, or game until a Health Care Provider has determined that the Student Athlete has not suffered a concussion. In the case where a Health Care Provider has determined that the Student Athlete has suffered a concussion, the Student Athlete may not resume practice, conditioning, or participation in games until medically determined capable of doing so for full or graduated return. In no circumstance may a Student Athlete return to a practice, conditioning or a game on the same day that a concussion has been diagnosed by a Health Care Provider or cannot be ruled out.

C. All Coaches must participate every year in a course of concussion management approved by the GISA. All Member Schools must maintain record of each Coach’s participation in the course. The on-line course in concussion management entitled “Concussion in Sports” and prepared by National Federation of High School Sports Associations is acceptable and is available free to Member Schools at www.nfhslearn.com.

III. Penalties.

Member Schools violating this policy shall be fined a minimum of $500.00 and a maximum of $1,000.00 for the first offense. A Member School may be removed from membership for repeat violations.

Approved by the GISA Board of Trustees this 29th day of July, 2013.

PHYSICAL PACKAGE PAGE 10
APPENDIX A

CONCUSSION INFORMATION FOR STUDENT ATHLETES

NAME OF SCHOOL: MEMORIAL DAY SCHOOL, SAVANNAH, GEORGIA

According to the article “Concussion” by the Mayo Clinic Staff, a concussion is defined and has symptoms as follows:

**Definition:**

A concussion is a traumatic brain injury that alters the way your brain functions. Effects are usually temporary, but can include problems with headache, concentration, memory, judgment balance and coordination. Although concussions usually are caused by a blow to the head, they can also occur when the head and upper body are violently shaken. These injuries can cause a loss of consciousness, but most concussions do not. Because of this, some people have concussions and don’t realize it.

Concussions are common, particularly if you play a contact sport, such as football. But every concussion injures your brain to some extent. This injury needs time and rest to heal properly. Luckily, most concussive traumatic brain injuries are mild, and people usually recover fully.

**Symptoms:**

The signs and symptoms of a concussion can be subtle and may not be immediately apparent. Symptoms can last for days, weeks or even longer.

The most common symptoms after a concussive traumatic brain injury are headache, amnesia and confusion. The amnesia, which may or may not be preceded by a loss of consciousness, almost always involves the loss of memory of the impact that caused the concussion.

Signs and symptoms may include: * Headache or a feeling of pressure in the head  * Temporary loss of consciousness  * Confusion or feeling as if in a fog

* Amnesia surrounding the traumatic event
* Dizziness or “seeing stars”
* Ringing in the ears
* Nausea or vomiting
* Slurred speech
* Fatigue

The well-being of its Student Athletes is of paramount importance to the School. Coaches are trained annually in recognizing the signs and symptoms of concussions and are required immediately to remove from practice, conditioning, or a game any Student Athlete who shows such signs. Student Athletes will not be permitted to return until a Health Care Provider has either ruled out a concussion or determines the Student Athlete capable of returning. In no instance will a Student Athlete with a diagnosed concussion return the same day.

PRINTED Student Name: ___________________________________________________
Signature of Student: ___________________________ Date:_____________

PRINTED Parent Name: __________________________________________________
Signature of Parent: ___________________________ Date:_____________


PHYSICAL PACKAGE PAGE 11