Athletics Department
Cross Creek High School
3855 Old Waynesboro Road Augusta, GA 30906
Ph: 706-772-8140 fax 706-772-8153

Student name _____ Grade _____
Last First

Your student has expressed an interest in participating in athletics at Cross Creek High School, below is a list of all sports offered each season. For any student to participate, they must have a current physical on file in the athletics office. A physical is considered current for one calendar year from the date it was completed by a doctor.

There are a number of forms that must be completed and on file before students may participate in high school athletics. This packet contains the following forms:* ~

- ❑ GHSA physical screening form
- ❑ Insurance information form (insurance policy number MUST be provided)
- ❑ Parent permission form
- ❑ Parent contract
- ❑ Military healthcare form (if applicable)
- ❑ Concussion awareness form
- ❑ Cardiac event awareness form
- ❑ Heat policy form
- ❑ Emergency contact card
- ❑ Football waiver (if applicable)

** If your student is covered by military healthcare there is an additional form that must be completed.*

~ If your student is participating in football, a Football waiver must be completed.

You may find any additional information regarding athletics at CCHS on the athletics webpage found under "Clubs and Organizations" on the CCHS school website. There you will also find contact information for the coaches of every sport. The coaching staff is excited for the upcoming school year as we look forward to competing at the highest level in each of our sports and we would like to welcome you to the CCHS Razorback family!

Fall	Winter	Spring
Cheerleading	Basketball	Baseball
Cross Country	Cheerleading	Golf
Football	Wrestling	Soccer
Softball		Tennis
Volleyball		Track & Field

To be completed by coach receiving packet:

Date _____ Signature _____

Authorization to Disclose Health Information

Athlete's Name: _____ Date of Birth: _____

I authorize AU Medical Center, Inc. to use or disclose the above named individual's health information as described below, concerning the period from July 1, 2024 to June 30, 2025.

_ Medical information, as specified:
_ Standard Document Set (Discharge Summary, History and Physical, Progress Notes, Test Results, Consults)
X Other (specify): **Pre-Participation Exam and any subsequent athletic injury or condition**
_ Entire Medical Record (justification required)
_ Psychiatric/Psychological Information
_ Drug/Alcohol Abuse Treatment Information
_ HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome)

This information may be disclosed to and used by the following individual or organization (circle ONE):

Name: Academy of Richmond County
Address: 910 Russell St., Augusta, GA 30904

Name: Hephzibah High School
Address: 4558 Brothersville Rd., Hephzibah, GA 30815

Name: Butler High School
Address: 2011 Lumpkin Rd., Augusta, GA 30906

Name: T.W. Josey High School
Address: 1701 15th St., Augusta, GA 30901

Name: Cross Creek High School
Address: 3855 Old Waynesboro Rd., Augusta, GA 30906

Name: Lucy C. Laney High School
Address: 1339 Laney Walker Blvd., Augusta, GA 30901

Name: Davidson Fine Arts Magnet School
Address: 615 12th St., Augusta, GA 30901

Name: RCTCM School
Address: 3200B Augusta Tech Drive, Augusta, GA 30906

Name: Glenn Hills High School
Address: 2840 Glenn Hills Dr., Augusta, GA 30906

Name: Westside High School
Address: 1002 Patriot's Way, Augusta, GA 30907

Name: AR Johnson Health Science & Engineering Magnet School
Address: 1324 Laney Walker Blvd, Augusta, GA 30901

Purpose: To assist the coaches, school administration, and Richmond County Board of Education with the athlete's ability to participate in athletics

Special Instructions: Only coaches from the particular sport or Athletic Director, School Administration may receive this information.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: **06/30/25**. If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information Management Services at (706) 721-2722.

_____ _____
Parent or Legal Representative Signature Date

_____ _____
If signed by Legal Representative, Relationship to Athlete Signature of Witness

PARENT PERMISSION
FOR STUDENT ATHLETIC PARTICIPATION

Dear Parent(s) or Guardians(s):

The school's athletic program is an integral part of the curriculum, and school personnel have devoted great effort to assure that participating students are protected in every way possible. However, participation in athletics includes a risk of injury which may range in severity from minor to long-term catastrophic, including paralysis and death.

Participants have the responsibility to help reduce the chance of injury. Participants must obey all safety rules and regulations, participate in all required physicals, report all physical problems to the coach or athletic trainer, follow a proper conditioning program and inspect personal protective equipment daily. Proper execution of skill techniques must be followed for every sport.

It is the policy of the Richmond County School System that all athletic participants provide either proof of insurance or purchase the student accident insurance policy that is sanctioned by the Board. The school's athletic program is not authorized to extend public funds for injuries; thus, it will be the responsibility of the parent or guardian to pay any costs for any injury, which is not covered by insurance.

PLEASE INITIAL EACH OF THE FOLLOWING STATEMENTS TO SHOW THAT THE STATEMENT HAS BEEN READ, UNDERSTOOD AND APPROVED:

_____ I consent to have my son/daughter represent his/her school in approved athletic activities except thos activities excluded by the examining doctor.

_____ I grant permission for my son/daughter to accompany any school team of which he/she is a member to out-of-town trips. The athlete will be transported to and from all events in school approved vehicles. Parent/Guardians wishing to have their son/daughter with them returning from an event must make written arrangements with the coach

_____ In the event of an emergency requiring medical attention, I understand every attempt will be made to contact me. In case I cannot be reached, I grant permission for any immediate treatment deemed necessary by the attending physician and transfer of my son/daughter to a qualified medical facility. This authorization does not cover major surgery unless formally decreed prior to surgery by two licensed physicians or dentists.

_____ I agree not to hold the school or anyone acting on its behalf responsible for any injury occurring to my son/daughter in the proper course of such athletic activities or travel.

_____ I acknowledge and accept that there are risks of physical injury involved in athletic participation which may result in permanent paralysis, mental disability, and death.

Date: _____ Signature: _____
(Parent/Legal Guardian)

Date: _____ Signature: _____
(Parent/Legal Guardian)

Richmond County School System Interscholastic **CONTRACT** for Parents and Student-Athletes

1. I understand that if my child does not maintain academic achievement, that he/she will be removed from participation until such grades have improved and academic expectations and requirements have been met.

2. I understand that my child is expected to attend all practices, rehearsals, meetings and events, to arrive promptly and to remain throughout the scheduled hours. I also agree to provide a written excuse for missed practices and pick up my child after practices, rehearsals, meetings and events have ended.

3. I understand that my child is to cooperate and conduct him or herself with Administrators, teachers, coaches, spectators, officials and team members in a manner showing respect to all persons.

4. I understand that my child must adhere to all school policies and the policies of the Richmond County Board of Education.

5. I understand that my child must maintain the highest standards of honesty and integrity while representing the school and the school system of Richmond County.

6. I understand that my child is to respect and care for all equipment and supplies issued by the Richmond County School System. I also understand that I am held financially responsible for any theft, damage or loss of any of the equipment or supplies issued to my child by the Richmond County School System.

The privilege of representing a school rests upon the personal responsibility of the child and the parent. In consideration of the County Board of Education of Richmond County offering athletics, extracurricular, co-curricular, and interscholastic activities and selecting my child as a member, I promise that my child will attend school regularly, maintain high academic standards, and be cooperative and respectful of others. This contract is for the _____ school year.

This contract becomes effective this _____ day of _____20_____.

Signature of parent or guardian Print Name

Signature of student Print Name

REVISED JULY 2023

ATHLETE ROSTER

Sport: _____

Name: _____ Birthdate: _____

Sex: [M] [F] Grade: _____

Address: _____

_____

Home Phone #: _____

Name of Parent/Guardian: _____

Address (if different from above)**: _____**

_____

Home Phone #: (Mother) _____ (Father) _____

Business Phone #: (Mother) _____ (Father) _____

PERSON OTHER THAN PARENT/GUARDIAN TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Relation: _____

Address: _____

_____

Phone#: (Home) _____ (Business) _____

FAMILY PHSICIAN INFORMATION:

Physician Name: _____ Specialty: _____

Address: _____

_____

Phone #: (Office) _____ (Emergency) _____

INSURANCE COMPANY INFORMATION:

Primary: _____ Policy #: _____

Secondary: _____ Policy #: _____

Specific medication, allergies, medical problems of the athlete:

_____

_____

Georgia High School Association
Student/Parent Concussion Awareness Form

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_____ 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 2024-2025 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: 7/24)

Georgia High School Association
Student/Parent Sudden Cardiac Arrest Awareness Form

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 _____ 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 2024-2025 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: 3/24)

Dear Parent,

The Executive Committee of the Georgia High School Association passed By-Law 2.67 establishing a policy that would modify practice schedules during times of extreme high temperatures and humidity. Every school must have a policy related to practice in extreme heat conditions, and a copy of the policy must be given to every athlete's parent(s). The parent must also sign the bottom of this letter stating that you have received a copy of Richmond County's Policy and Guidelines for Middle and High School Students to Prevent Heat Related Illnesses.

For several years, the Richmond County School System has had a policy related to practice during extreme heat. The guidelines within the Heat Safety section of the Athletics Handbook refer only to coaches when they are performing coaching duties. It does not cover nor is it intended to cover the duties of anyone during their role as a teacher. If at any time you feel that a coach is not abiding by our policy, please contact the school's Principal or you may call me at (706) 826-1126.

Thank you for your cooperation.

Sincerely,

Scott McClintock

Scott McClintock
Director of Athletics
Richmond County School System

I am the parent or legal guardian of _____, who is

a student at _____school.

I understand the Richmond County School System has developed a policy related to the Prevention of Heat Related Illnesses. This policy is in accordance with By-Law 2.67 of the Georgia High School Association, and that I have received a copy of that policy.

Parent Signature _____ Date _____

■ 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 ≥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?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

Explain "Yes" answers here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

2023 This form has been modified for use by the GHSA

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____
(First Name) (Last Name)

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

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
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 • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] 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: _____

_____

_____

Emergency Medical Card

Student name: _____ Date of Birth: ___ / ___ / _____

Name of Parent/Guardian: _____

Cell Phone #: _____ Home/Work Phone #: _____

Name of Physician: _____ Phone: _____

Name of Insurance Company: _____ Policy #: _____

Preferred Medical Facility: _____

Allergies: Yes ___ No ___ Type: _____

List medications: _____