

Name: \_\_\_\_\_

Grade: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

Packet Cleared Through: \_\_\_\_\_

**Athletes Checklist:**

\_\_\_\_\_ Page 1 – History

\_\_\_\_\_ Page 2 – Physical Examination – MUST BE COMPLETED & **STAMP** BY DOCTOR'S OFFICE

\_\_\_\_\_ Page 3 – Clearance Form

\_\_\_\_\_ Page 4 – Athletic Roster

\_\_\_\_\_ Page 5 – Parent Permission Form

\_\_\_\_\_ Page 6 - Student/Parent Concussion Awareness Form

\_\_\_\_\_ Page 7 - Interscholastic Contract for Parents & Student-Athletes

\_\_\_\_\_ Page 8 – Awareness of Football Risk (Football Only)

\_\_\_\_\_ Page 9 - Sudden Cardiac Arrest Form

\_\_\_\_\_ Page 10 – Emergency Medical Card

\_\_\_\_\_ Page 11 – Practice Policy for Heat & Humidity

\_\_\_\_\_ Copy of Insurance Card – front & back

\_\_\_\_\_ Copy of latest Report Card

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**Academic Clearance** (Athletic Director)

**FALL \_\_\_\_\_ Academic Clearance**

Date/s Cleared: \_\_\_\_\_

Verified by Athletic Director: \_\_\_\_\_

**SPRING \_\_\_\_\_ Academic Clearance**

Date/s Cleared: \_\_\_\_\_

Verified by Athletic Director: \_\_\_\_\_

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

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ 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 of your allergies (i.e., 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

**GENERAL QUESTIONS** (Explain "yes" answers at the end of this form. Circle questions if you don't know the answers.)

	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has a provider ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any ongoing medical issues or recent illnesses?	<input type="checkbox"/>	<input type="checkbox"/>

**HEART HEALTH QUESTIONS ABOUT YOU**

	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Has a doctor ever told you that you have any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you ever get light-headed or feel shorter of breath than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>

**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)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long or short QT syndrome (LQTC or SQTC), Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has anyone in your family had a pacemaker or an implanted defibrillator before the age 35?	<input type="checkbox"/>	<input type="checkbox"/>

**BONES 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?	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>

**MEDICAL QUESTIONS**

	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
17. Are you missing a kidney, an eye, a testicle (male), a spleen, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have any recurring skin rashes or rashes that come & go, including herpes or	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms & legs after being hit or fallen?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you ever become ill while exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you or someone in your family have sickle cell trait or disease?	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you ever had or do you have any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you worry about your weight?	<input type="checkbox"/>	<input type="checkbox"/>
26. Are you trying to or has anyone ever recommended that you gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
27. Are you on a special diet or do you avoid certain types of foods or food groups?	<input type="checkbox"/>	<input type="checkbox"/>
28. Have you ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>

**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: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## ■ 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: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)	<input type="checkbox"/>	
Eyes, ears, nose, and throat • Pupils equal • Hearing	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	
Heart <sup>a</sup> • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck	<input type="checkbox"/>	
Back	<input type="checkbox"/>	
Shoulder and arm	<input type="checkbox"/>	
Elbow and forearm	<input type="checkbox"/>	
Wrist, hand, and fingers	<input type="checkbox"/>	
Hip and thigh	<input type="checkbox"/>	
Knee	<input type="checkbox"/>	
Leg and ankle	<input type="checkbox"/>	
Foot and toes	<input type="checkbox"/>	
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test	<input type="checkbox"/>	

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: \_\_\_\_\_

## ATHLETIC ROSTER

Sport(s): \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Sex: (M) \_\_\_\_\_ (F) \_\_\_\_\_ Grade: ( \_\_\_\_\_ )

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

Phone # (Home/Cell): \_\_\_\_\_

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

Address if different from above: \_\_\_\_\_

Home/Cell Phone #: (Mother) \_\_\_\_\_ (Father) \_\_\_\_\_

Work Phone #: (Mother) \_\_\_\_\_ (Father) \_\_\_\_\_

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

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

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

Phone #: (Cell) \_\_\_\_\_ (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

### **FAMILY PHYSICIAN INFORMATION:**

Physician's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address/Location: \_\_\_\_\_

Phone #: (Office) \_\_\_\_\_ (Emergency) \_\_\_\_\_

### **INSURANCE COMPANY INFORMATION: (\*\*\*) Attach a copy of the front & back of insurance card)**

Primary: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary: \_\_\_\_\_ Policy#: \_\_\_\_\_

Specific medication, allergies, medical problems of the athlete: \_\_\_\_\_

**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 those 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 events in school approved vehicles. Parents/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)

Revised: 5-20-22

# Georgia High School Association

## Student/Parent Concussion Awareness Form

SCHOOL: John M. Tutt Middle 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 John M. Tutt Middle 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 \_\_\_\_\_ school year. This form will be stored with the athletic physical form and other accompanying forms required by the \_\_\_\_\_ Richmond County School System.

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

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

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

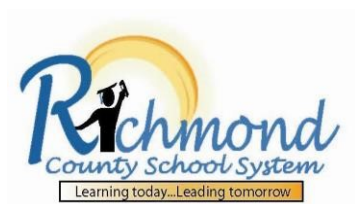
\_\_\_\_\_  
Date

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

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

\_\_\_\_\_  
Date

(Revised: 3/21)



## **Interscholastic CONTRACT for Parents and Student-Athletes**

1. I understand that each participating student in athletics, extracurricular, co-curricular and interscholastic activities is expected to maintain at least a 70 average in order to remain eligible. I also understand that progress reports will be done every three (3) weeks and I must sign the report and return to the school. I also 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, cocurricular, 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 the \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

X \_\_\_\_\_  
Signature of parent or guardian

X \_\_\_\_\_  
Signature of student



**AWARENESS OF FOOTBALL RISK**

The coaches in our football program are well qualified professional people who emphasize the proper fundamentals related to playing the game of football. Regardless of this fact, being a contact sport, injuries will occur. It is the purpose of this handout to not only inform the player and the parent of this, but also to make them aware of the safety precautions that must be adhered to in order to either prevent or to minimize injuries.

By rule, the helmet is not to be used as a ‘ram’. It is not possible to play the game safely or correctly without making some contact with the helmet when properly blocking and tackling, but proper technique would be for the initial contact to be made for the shoulder. In addition, the head should never be bent downward when making contact. If the head is bent downward on contact or if the contact is on the top of the helmet serious injury could possibly occur, including dislocation, nerve damage, paralysis or even death.

Rules also prohibit a player from blocking below the waist outside a two yard by 4 yard area next to the football. This was an important rule change that was made to help minimize the number of serious knee and ankle injuries.

It is important also that the uniform, especially the helmet and shoulder pads properly fits. All players should have some basic knowledge of the correct fitting of the uniform. Shoulder pads are too small will leave the shoulder point vulnerable; to bruises and separation. If they are too tight in the neck area, a pinched nerve could result. Shoulder pads that are too large will leave the neck area poorly protected and will slide on the shoulders, making the vulnerable to bruises and separation.

Helmets must fit snugly at the contact points: front, back, and top of the head. The helmet must be safely “NOCSAE” branded and a warning sticker must be on it. On contact a helmet too tight could produce a headache. One too loose could produce headache, concussion, a face injury such as a broken nose or cheek bone or a serious neck injury. No player should practice until, both he and the coach are satisfied with the proper fit of the helmet.

This handout does not cover all potential injury possibilities in playing football, but it is an effort to make both the players and the parents aware of the fact that proper techniques adhering to the rules of the game and properly fitting equipment are vital to each player’s safety and enjoyment of the game.

.....

We understand the information presented and are aware of the risks involved in playing football. We also understand that the player must accept a major role in the prevention of serious injuries by adhering to the rules, by using proper technique and by using only properly fitted equipment.

- \_\_\_\_\_  
Signature of Athlete
- \_\_\_\_\_  
Signature of Parent or Guardian
- \_\_\_\_\_  
Date

## Georgia High School Association

### Student/Parent Sudden Cardiac Arrest Awareness Form

SCHOOL: John M. Tutt Middle 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 Tutt Middle 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 \_\_\_\_\_ school year. This form will be stored with the athletic physical form and other accompanying forms required by the Richmond County 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

## 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: \_\_\_\_\_

Athletics #4 (New 7-17)



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.

**WBGT ACTIVITY GUIDELINES AND REST BREAK GUIDELINES**

- 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. For Football: 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. For All Sports: 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. For Football: no protective equipment may be worn during practice, and there may be no conditioning activities. For All Sports: 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.

- (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.
- (g) When the WBGT reading is over 86, ice towels and spray bottles filled with ice water should be available at the "cool zone" to aid the cooling process AND cold immersion tubs must be available for the benefit of any player showing early signs of heat illness. In the event of a serious EHI, the principle of "Cool First, Transport Second" should be utilized and implemented by the first medical provider onsite until cooling is completed (core temperature of 103 or less).

Head Coach's Signature \_\_\_\_\_ Date \_\_\_\_\_

Athletes Name \_\_\_\_\_ Parent Signature \_\_\_\_\_ Date \_\_\_\_\_