

FULTON COUNTY SCHOOL SYSTEM DEPARTMENT OF ATHLETICS

VERIFICATION OF INSURANCE COVERAGE

Effective for School Year 2023-2024

I have waived the medical/health insurance coverage that has been approved by the Fulton County School System and offered to my child, _____ Date of Birth: _____
(Name of Child)

The medical/ health insurance that I am using for my child for the current school year at _____ is provided by _____ and
(School Name) (Name of Insurance Company)
the insurance policy number is _____. This insurance policy
(Insurance Policy Number)
is in effect from: _____ to _____
(Date) (Date)

Attach a copy of Medical/Health Insurance Certificate to this form to verify information listed above. Thank you.

The above medical/health insurance coverage provides for the following interscholastic athletics activities:

1. _____
2. _____
3. _____
4. _____

We/I understand that per The Georgia High School Association a Pre-participation Physical evaluation must be performed by a physician to medically screen each student who participates in the interscholastic athletic programs of the Fulton County School District. We/I understand that a basic medical screening (the required physical exam) is general in nature and limited in scope and does not indicate or assure me/us that my/our child is completely free from impairments. If I/we wish for a more detailed physical exam to be performed upon my/our child then it is my/our responsibility to arrange and to pay for such an exam. If this more detailed exam is performed, it is my/our responsibility to notify the Fulton County School District, and it's appropriate employees, of any potential medical problems uncovered by any physical exam given to my/our child other than the general physical required by the school system for athletic participation. I agree to fully waive any and all claims of whatever nature, fully and finally, now and forever, for my/our child, for myself, my estate, my heirs, my administrators, my executors, my assignees, my agents, my successors, and for all members of my family, and to indemnify, release, defend, exonerate, discharge and hold harmless all current, former and future members of the School Board of the Fulton County Board of Education, all current, former and future employees of the Fulton County Board of Education, their schools, their trustees, officers, Board of Education, agents, coaches, athletic trainers, physicians, volunteers, and any other practitioner of the healing arts (an "Indemnified Party") from any and all liability, personal or property damages, claims, causes of action or demands brought against the Fulton County School District or indemnified party arising out of any injuries to my/our child or to his or her property or losses of any kind which may result from or in connection with his or her participation in any activity related to the interscholastic athletic programs provided by the Fulton County School District.

My signature below attests that I have read, understood and concur with the information on this form, and that I give consent for my child to participate in the athletic programs as stated above.

ALL PARENTS/GUARDIANS/ MUST SIGN BELOW AND DATE

Signature of parent/guardian: _____ Date: _____

Signature of parent/guardian : _____ Date: _____

Signature of student : _____ Date: _____

PRIOR TO PARTICIPATION IN ANY CONDITIONING, TRYOUT, PRACTICE SESSION, OR PLAY IN ANY INTERSCHOLASTIC ATHLETIC ACTIVITY, THE STUDENT-ATHLETE MUST SUBMIT THIS FORM FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS TO THE COACH OF THE ACTIVITY. FAILURE TO SUBMIT THIS FORM WILL DELAY THE ELIGIBILITY OF THE STUDENT-ATHLETE TO JOIN THE TEAM

FULTON COUNTY SCHOOL SYSTEM DEPARTMENT OF ATHLETICS

**STUDENT'S APPLICATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS
AND VERIFICATION OF INSURANCE**

Sport: _____ Date of first practice: _____, 2023/2024

Student Name: _____ Male ☐ or Female ☐
(Last name) (First name) (MI)

Date of Birth: _____ Age: _____ years old
(Month) (Day) (Year)

Address: _____
(# and Street Name) (City) (State) (Zip Code)

Home Telephone #: _____ Emergency Telephone # _____

Cellular Telephone #: _____

This application to represent my school in interscholastic activities is entirely voluntary on my part and is made with the understanding that I have studied and understood the Eligibility Standards that I must meet to represent my school and that I have not violated any of these standards. I understand that not meeting the standards set by the school or being ejected from an interscholastic contest because of an unsportsmanlike act, could result in my not being allowed to participate in the next contest or suspension from the team either temporarily or permanently. I understand that if I transfer to another school my eligibility may be affected under the Georgia High School Association's eligibility standards.

Student Signature: _____
(Signature) (School) (Date)

I hereby consent for the above student to represent his/her school in interscholastic activities. I have received a Student/Parent Handbook for GHSA Sanctioned Interscholastic Activities 2023-2024. I understand that I am responsible for reading the contents of this publication and that questions related to this publication can be addressed to the Fulton County Athletic Director at 470-254-6892. If I, the parent(s)/guardian(s), cannot be reached in the event of a medical emergency, I do give consent for the school to obtain emergency transportation to the physician or hospital of its choice, and such medical care as is reasonably necessary for the welfare of the student if he/she is injured in the course of participation in interscholastic activities. I give permission for the above student to participate in school-sponsored trips, including overnight trips, associated with Fulton County School's interscholastic athletic competitions. In the event that transportation is not provided by the Fulton County School System, transportation will be the student's or the parent's /guardian's responsibility. In addition, I agree not to assert against the Fulton County Board of Education, all current, former and future members of the School Board of the Fulton County Board of Education, all current, former and future employees and/or volunteers of the Fulton County Board of Education, and their heirs, executors, administrators, successors, and assigns, in any court of law, any claim or claims that the student and/or parent or legal guardian had, now have, or may have in the future, whether known or unknown, arising out of, during, or in conjunction with the student's participation in the activity, any trip, or transportation associated with the activity, or the rendering or emergency medical procedures or treatment, if any.

All parents and guardians must sign and date this form

Signature of parent/guardian: _____ Date: _____

Signature of parent/guardian: _____ Date: _____

PRIOR TO PARTICIPATION IN ANY CONDITIONING, TRYOUT, PRACTICE SESSION, OR PLAY IN ANY INTERSCHOLASTIC ATHLETIC ACTIVITY, THE STUDENT-ATHLETE MUST SUBMIT THIS FORM FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS TO THE COACH OF THE ACTIVITY. FAILURE TO SUBMIT THIS FORM WILL DELAY THE ELIGIBILITY OF THE STUDENT-ATHLETE TO JOIN THE TEAM.

FULTON COUNTY ATHLETIC
EMERGENCY CONTACT FORM
2023-24

High School: _____

Athlete Information:

Sport: _____ Grade: _____

Date Prepared: _____

Athlete Name: _____ Date of Birth: _____

Home Address: _____

Home Phone Number: _____ Parent Name(s): _____

In case of an emergency, please contact in the following:

1) Name _____ Relationship: _____

Phone Numbers: (H) _____ (C) _____ (W) _____

2) Name _____ Relationship: _____

Phone Numbers: (H) _____ (C) _____ (W) _____

Insurance Information: (Every athlete must have medical coverage through an individual policy or purchased through Fulton County School System).

Insurance Company: _____ Policy Number: _____

OR: Indicate School Insurance Purchased _____

Medical Information:

Date of Last Physical: _____

Please list any known allergies: _____

Please list ongoing medical conditions and current medications: _____

_____ Please list previous injuries: _____

_____ Has the athlete ever had a concussion? _____

Please note any known medical issues which should be known by medical personnel upon treatment: _____

Permission to Treat:

- In the event of a minor injury or discomfort, I give permission for the athletic trainer to treat the athlete as needed.
- If the parent/guardian/other (listed above) cannot be reached in the event of a medical emergency, I do give consent for the school to obtain emergency transportation to the hospital of its choice and such medical care as is reasonably necessary for the welfare of the athlete if he/she is injured in the course of participation in interscholastic activities.

Signature of Parent or Guardian:

Name: _____ Date: _____

Fulton County School Transportation Release 2023-24

Since your student will be transported between school sites, events, activities during and after the school day, please complete and sign the following form, and return it to your coach.



I wish for my student to be transported by Fulton County bus transportation ONLY.



I wish to designate additional person(s) who may transport my student (see below).

I agree to hold Fulton County Board of Education harmless in the event of injury to (student's name), including any property damage while the student is driving or being driven to or from a school site and/or to school-related events, activities, or sites after school hours in a vehicle other than that provided by Fulton County Board of Education.

In addition, I agree not to assert against the Fulton County Board of Education, all current, former and future members of the School Board of the Fulton County Board of Education, all current, former and future employees and/or volunteers of the Fulton County Board of Education, and their heirs, executors, administrators, successors, and assigns, in any court of law, any claim or claims that the student and/or parent or legal guardian had, now have, or may have in the future, whether known or unknown, based on any injuries sustained by the student while being so transported.

I have read the above agreement, and voluntarily sign the release and waiver of liability, and further agree that no oral representations, statements or inducements apart from the foregoing written agreement have been made.

Signature of Parent or Legal Guardian: _____ Date: _____

Signature of Student Athlete: _____ Date: _____

Designated Driver (if applicable): All designated drivers must be over 18 years of age or an immediate family relative.

(Student's Name) _____ has my permission to be transported to and from school sites during the school day and/or to school-related events, activities, or sites after school hours as a participant on the _____ School _____ Team. Either I or my designated driver, _____ will be transporting the student to and/or from the event or activity. Either I or my designated driver will present himself or herself to the head coach and/or assistant coach after the event or activity has been completed in order to verify the intent to transport the above mentioned student.

Signature of Parent or Legal Guardian: _____ Date: _____

Signature of Student Athlete: _____ Date: _____

Signature of Designated Driver: _____ Date: _____

(FOR SCHOOL USE ONLY)

Received by : _____ on _____
(print full name) (print date)

Signature of receiving party: _____

PRIOR TO PARTICIPATION IN ANY CONDITIONING, TRYOUT, PRACTICE SESSION, OR PLAY IN ANY INTERSCHOLASTIC ATHLETIC ACTIVITY, THE STUDENT ATHLETE MUST SUBMIT THIS FORM TO THE COACH OF THE ACTIVITY. FAILURE TO SUBMIT THIS FORM WILL DELAY THE ELIGIBILITY OF THE STUDENT-ATHLETE TO JOIN THE TEAM.

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

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

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

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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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)	GENERAL QUESTIONS		Yes	No
	(Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)			
	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 illness?	<input type="checkbox"/>	<input type="checkbox"/>	
(Last Name)	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"/>	

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)		Yes	No
9. Do you 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 QT syndrome (LQTS), short QT syndrome (SQTS), 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 age 35?	<input type="checkbox"/>	<input type="checkbox"/>	

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

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

PHYSICIAN REMINDERS

- Consider additional questions on more-sensitive issues.
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ (/)	Pulse: _____	Vision: R 20/ _____ L 20/ _____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Pupils equal Hearing 	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Skin <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Double-leg squat test, single-leg squat test, and box drop or step drop test 	<input type="checkbox"/>	

^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: _____

■ PREPARTICIPATION PHYSICAL EVALUATION

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: _____ Date of birth: _____

1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or 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 as having 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 whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (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 questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

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 2023-2024 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

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 2023-2024 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: 3/23)



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 _____