FULTON COUNTY SCHOOL SYSTEM DEPARTMENT OF ATHLETICS

VERFICATION OF INSURANCE COVERAGE

Effective for School Year 2022-2023

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:** _____, 2022/2023

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 2020-2021. 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
2022-2023

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) _____

1) 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:

- Inthe 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 2022-23

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: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

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.)

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?	☐	☐

FEMALES ONLY	Yes	No
29. Have you ever had a menstrual period?	☐	☐
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

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: _____

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, 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: _____

_____

_____

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 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 2022-2023 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: 3/21)

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 2021-2022 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: 3/21)