WARNER ROBINS HIGH SCHOOL ATHLETICS

401 South Davis Drive
Warner Robins, GA 31088
(478) 929-7877 Fax (478) 929-7769

Denny Maddox, Athletic Director **Chris McCook,** Principal

Process for Student Participation in Spring Sports Physicals at WRHS.

- Fill out all sections of the attached packet and return it with $15 fee to WRHS Main Office by May 3, 2024
- Login to/create a Dragonfly Max account and link to your High School. https://max.dragonflyathletics.com/maxweb/max-cover/login) Do not create a new account if you already have one. Students should fill out all the forms on Dragonfly for the 2024-2025 school year. ALL PARTS MUST BE COMPLETED! You Physical Exam form and Medical Eligibility form

Warner Robins High School [2024-25]

Complete the following steps for Torrionna to be eligible to play :

UPDATE MEDICAL & DEMOGRAPHIC INFO FOR 2024-25	START
YOUR SPORT(S) FOR 2024-25	
NO TEAMS FOUND (2023)	CONFIRM / UPDATE SPORTS
Sports must be confirmed for each year.	
ELECTRONIC SIGNATURE AGREEMENT	START
HHC PATIENT PRIVACY ACKNOWLEDGEMENT AND CONSENT	START
HCSD EMERGENCY CONTACT AND MEDICAL AUTHORIZATION	START
HCSD PARENTAL CONSENT FOR PARTICIPATION	START
HHC AUTHORIZATION FOR MEDICAL EXAMINATION AND TREATMENT 2024 FORM	START
GHSA STUDENT / PARENT SUDDEN CARDIAC ARREST AWARENESS FORM	START
GHSA STUDENT / PARENT CONCUSSION AWARENESS FORM	START
GHSA HEAT AND HUMIDITY POLICY FOR ALL SPORTS	START
GHSA HEALTH HISTORY FORM	START

- Fill out the History portion of the Pre-participation Physical Form (Page 1-2). Turned in no later than May 3
- Payment for Spring Physical Exams is due prior May 3. Payment should be made to the school. (cash or check) Checks should be written to WRHS. Turn in with completed packet to Main Office.
- Students who have completed packet and paid will be given instruction during 6th and 7th periods on May 10 for physicals. Only students who have paid and completed the packet will be allowed to participate in Spring Sports Physicals.

We can, we will, we must ....change lives!

School Physicals Permission Form

The Houston County School District will be working in conjunction with Houston Health Care to provide physicals for all Houston County student athletes. In an effort to assist students, staff, and parents, these physicals will be held during the school day starting at 1:15 p.m. and ending at 4:00 p.m. at each high school. Middle school student athletes who wish to participate in this event will attend at their assigned feeder high school (listed below) and will be transported by bus and/or parent after their 2:30 p.m. dismissal time. The cost of a physical is $15 per athlete. Payment can be cash or a check made out to your child's school. Your child will need to have this permission form completed along with other documents that will be provided by your school prior to attending physicals. Below is a list of physical dates, times, and locations.

- **April 12, HCHS** 1:15 p.m.- 4:00 p.m. (New Gym)
  - FMMS and MCMS 2:45 p.m.- 4:00 p.m.
- **April 19, NHS** 1:15 p.m.- 4:00 p.m. (New Gym)
  - TMS and NMS 2:45p.m.- 4:00 p.m.
- **April 26, VHS** 1:15 p.m.- 4:00 p.m. (Old Gym)
  - BMS 2:45 p.m.- 4:00 p.m.
- **May 10, WRHS** 1:15 p.m.- 4:00 p.m. (~~New~~ Old Gym)
  - HMS and WRMS 2:45 p.m.- 4:00 p.m.
- **May 17, PHS** 1:15 p.m.- 4:00 p.m. (New Gym)
  - PMS 2:45 p.m.- 4:00 p.m.

I hereby give permission for _____ *to participate in this activity.*
(Name of Student)

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

Middle Schools Only: I give permission for my child's school to transport my child via school bus to their designated high school to participate in physicals. I will pick up my child at their home school at the conclusion of physicals.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

Houston County School District
Health Related Services

HOUSTON COUNTY SCHOOL DISTRICT
High School Athletic Permission and Medical Form

Please PRINT the following information.

Student's Last Name *Student's First Name* *School*

Name of Parent(s) *Student's Date of Birth*

Address *(Street)* *(City, State Zip)*

Phone #'s (Cell) *(Work)* *(Cell)* *(Work)*

Does your child have any **life-threatening allergies**? *(circle one)* **Yes** **No**
If answer is yes, please list and explain:

Does your child require any emergency medication(s)? (circle all that apply) **Epinephrine** **Inhaler** **Glucagon** **Seizure Rescue Med**
Do they keep their emergency medication with them? If so, where?
If answer is **yes**, please list medication(s) and any **necessary instructions**:

Please list any additional medical information we should know about your child *(continue on back if needed)*

In the event my child needs medication for minor aches or illness after school and at out-of-county athletic events, I give their athletic coach permission to give my child the following over the counter medication(s) if necessary. Medications will be administered based on the manufacture's instruction on the package:

(circle one)

Acetaminophen	**Yes**	**No**	For headache/ fever/ cramps
Benadryl	**Yes**	**No**	For allergy / insect stings
Dramamine	**Yes**	**No**	For motion sickness
Children's Pepto Bismol	**Yes**	**No**	For stomachache / diarrhea
Ibuprofen	**Yes**	**No**	For pain/ fever

Medical Release Statement

Should my child need immediate medical attention, the teachers/coaches/chaperones have my permission to seek immediate medical treatment. I give permission for the above-listed medications to be given per directions.

Parent's Signature *Date*

Name of Insurance Company *Policy and Group #*

If I cannot be reached in the case of an emergency, please call:

Name *Relationship*

Phone #'s (Cell) *(Work)*

■ 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: _____

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.

SEE NEXT PAGE

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: _____

HOUSTON HEALTHCARE

Authorization for Medical Examination and Treatment of Student Athletes

Name of Athlete: _____

Address: _____

City/State/Zip: _____

Athlete's DOB: _____

The term of this authorization covers school year: _____

The Student Athlete identified above participates in an athletic program at _____. As a participant in the athletic program(s) of the school, I understand that he/she will be under the care of Certified Athletic Trainers who are provided by Houston Healthcare. I do hereby consent to any examination, medical care and/or treatment deemed medically necessary or appropriate by a team physician (see list below), athletic trainer and/or coach.

Dr. W. Steven Wilson – Family Practitioner
Dr. Jonathan S. Harris – Ortho Georgia
Dr. Brian J. Ludwig – Ortho Georgia
Dr. Zaneb Yaseen – Ortho Georgia
Dr. Todd E. Kinnebrew – Ortho Georgia
Dr. Scott K. Malone – Middle Georgia Orthopedics
Dr. William B. Wiley – Middle Georgia Orthopedics
Dr. David H. Wiley – Middle Georgia Orthopedics
Dr. Jeffrey C. Easom – Middle Georgia Orthopedics
Dr. Derek D. Phillips – Middle Georgia Orthopedics

This consent to treat is granted pursuant to the provisions of the Georgia Medical Consent Law (Official Code of Georgia Annotated, Title 31, Chapter 9) and shall be construed in accordance with that statute.

I give consent for Houston Healthcare Athletic Trainers to communicate with the following primary care physician as needed related to care and treatment for participation in the athletic program:

Provider name and contact information: _____

Parent Signature: _____

Date: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

HOUSTON HEALTHCARE

Patient Privacy Acknowledgement and Consent

I acknowledge that I have received instructions on how to obtain a copy of the Houston Healthcare Notice of Privacy Practices, effective April 14, 2003 (*revised September 23, 2013)*. I consent to the uses and disclosures of my health information as defined in the Notice.

The Houston Healthcare Notice of Privacy Practices is located on our website: https://www.hhc.org/For-Patients/Privacy-Practices. **A copy of the Notice of Privacy Practices can be viewed and printed from the website. If you have any questions regarding the Notice of Privacy Practices, please contact the Houston Healthcare Privacy Officer at (478) 922-4281.**

Print Name (student athlete): _____

Print Name of Parent/Representative: _____

Signature of Parent/Representative: _____

Date: _____

Please describe the Representative's authority to act on behalf of the Patient:

- ☐ The representative is the parent of the patient who is a minor.
- ☐ The representative is the guardian of the patient who has been adjudicated incompetent.
- ☐ The representative is acting under a Durable Power of Attorney for Health Care of the Patient and has provided documentation of such to Houston Healthcare.