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 the assigned feeder high school (listed below) and will be transported by bus 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 10, WRHS 1:15 p.m.- 4:00 p.m. (Competition Gym)**
  - **HMS and WRMS 2:45 p.m.- 4:00 p.m.**
- **April 11, PHS 1:15 p.m.- 4:00 p.m. (Competition Gym)**
  - **PMS 2:45 p.m.- 4:00 p.m.**
- **April 17, NHS 1:15 p.m.- 4:00 p.m. (Competition Gym)**
  - **TMS and NMS 2:45p.m.- 4:00 p.m.**
- **April 18, VHS 1:15 p.m.- 4:00 p.m. (Competition Gym)**
  - **BMS 2:45 p.m.- 4:00 p.m.**
- **April 25, HCHS 1:15 p.m.- 4:00 p.m. (Competition Gym)**
  - **FMMS and MCMS 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)*

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.

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

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.

In the event this athlete receives care at a Houston Healthcare Med-Stop facility for a school sports related injury, I give consent for the Houston Healthcare Athletic Trainers to communicate with the facility as needed related to care and treatment for participation in the athletic program.

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: _____

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

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

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

Date of examination: _____ Sport(s): _____

Sex assigned at birth: _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

*Over the last 2 weeks, how often have you been bothered by any of the following problems? **(check box next to appropriate number)***

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	☐0	☐1	☐2	☐3
Not being able to stop or control worrying	☐0	☐1	☐2	☐3
Little interest or pleasure in doing things	☐0	☐1	☐2	☐3
Feeling down, depressed, or hopeless	☐0	☐1	☐2	☐3

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

(First Name)

(Last Name)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?	☐	☐
2. Has a provider ever denied or restricted your participation in sports for any reason?	☐	☐
3. Do you have any ongoing medical issues or recent illness?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?	☐	☐
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	☐	☐
7. Has a doctor ever told you that you have any heart problems?	☐	☐
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	☐	☐

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	☐	☐
10. Have you ever had a seizure?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?	☐	☐
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	☐	☐
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	☐	☐

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

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

Explain "Yes" answers here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

2023 This form has been modified for use by the GHSA

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

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

PHYSICIAN REMINDERS

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

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

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____