

WRHS Sports Participation Information

In order to practice and compete in sports at WRHS, each of the following items must be completed on DragonFly Max BEFORE the start date of the sport.

Warner Robins High School [2024-25]

Complete the following steps for Amauria 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
GHSA PHYSICAL EXAMINATION FORM	START
GHSA MEDICAL ELIGIBILITY FORM	START

To fill out these forms, log in to athlete's account on DragonFly Max (<https://max.dragonflyathletics.com/maxweb/max-cover/login>) and tap to fill out the school's paperwork. **If an athlete already has a login DO NOT CREATE A NEW ONE.** If they have forgotten their password, do a password reset.

If athlete does not have a DragonFly Max account, they will need to create one by logging in to www.dragonflymax.com and sign up for free, or by downloading the app (App Store or Google Play) and signing up for free. Be sure to use the School Name: **Warner Robins High School**, and/or the School Code: **HX78EY**. Once they have created their profile, the athlete will need to complete all the forms above.

Completing DragonFly Information.

The school will have to approve the **GHSA Physical Exam Form** and **GHSA Medical Eligibility Form** once those have been returned to the school or uploaded to DragonFly Max. Make sure the correct forms are uploaded clearly WITH a doctor's signature. **Incorrect forms will be rejected.**

Also attached is the **Houston County School District High School Athletic Permission and Medical Form**. This form must be completed and returned to the school. These forms are required for all athletes and travel with the coaches to away games and events.

GET STARTED WITH DRAGONFLY



DragonFly makes sports and activities more organized with easy-to-use digital forms, health records and team communication tools.



PARENTS & STUDENTS

- 1 Visit dragonflymax.com and click the 'Log In/Sign Up' button.
- 2 Click 'Sign Up for Free' then follow the prompts to create your Parent account with your own email address.
Note: please do not create an account with your child's name or contact information – you will get the chance to add your child soon!
- 3 Verify your account with the verification ID sent to your email address.
- 4 Click 'Connect to your school' to select 'Parent' as your role and search for your child's school.
- 5 After selecting your child's school, click 'Join' to request access. An administrator at your school will approve your request.
- 6 Click 'Set up your children' and follow the prompts to add your kid(s) and fill out their participation forms.



ATHLETIC DIRECTORS, COACHES & SCHOOL ADMINISTRATORS

- 1 Visit dragonflymax.com and click the 'Log In/Sign Up' button.
- 2 Click 'Sign Up for Free' to create your account with your school email address.
- 3 Verify your account with the verification ID sent to your email address.
- 4 Click the 'Get Started' button to select your role and search for your school.
- 5 After selecting your school, click 'Join' to request access. You will see a list of administrators at your school who can approve your request. If you're the first person to request access to your school, a member of the DragonFly team will verify your role and approve your request.

PREFER TO USE A MOBILE DEVICE?

Visit dragonflymax.com in your mobile browser and follow the steps above.

■ 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	<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.)

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 <i>Staphylococcus aureus</i> (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: _____

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

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: ft	in	Weight: lbs
BP: / (/)	Pulse: bpm	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) 		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> Pupils equal Hearing 		
Lymph nodes		
Heart* <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (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 <ul style="list-style-type: none"> Double-leg squat test, single-leg squat test, and box drop or step drop test 		

* 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:

