Tattnall County High School
Athletic Participation Consent Form
(2025-2026 School Year)
Department of Athletics

Students Name: _____ Student's Grade: _____ Student's Date of Birth: _____

Sport(s): _____

Parent/Guardian Name: _____

Home Phone: _____ Cell: _____ Work: _____

Student's Cell Phone: _____

***Note: Student's Special Medical Needs or Conditions:**

_____

_____

Allergies: _____ Carries an EpiPen: Y / N Carries an Inhaler: Y / N

Daily Medications: _____

Medical Insurance Company (if none please mark N/A): _____

Policy Number: _____

Emergency Contact Name & Number(s): _____

Emergency Contact Relationship to Athlete: _____

Athletic Participation Risks & Parent Consent:

My child has the opportunity to participate in intramural and interscholastic organized sports and athletic activities provided or sponsored by Tattnall County High School. I fully realize and acknowledge that, even with coaching and the use of equipment, injuries are a possibility in any sport activity, and I recognize that, on rare occasions, these injuries can be so severe as to result in total disability, paralysis, or even death. Realizing such, and in consideration of my child being allowed to participate in intramural and interscholastic organized sports and athletic activities provided or sponsored by Tattnall County High School.:

1. I give my express permission for my child to participate fully in any intramural and interscholastic organized sports and athletic activities provided or sponsored by Tattnall County High School. (including such travel as may be incident to such participation);
2. I assume all risks, included any risks associated with any special medical needs or condition of my child*, of my child's participation in any such sport or activity (including travel incident thereto):
3. I authorize any coach or other adult supervision any sport or athletic activity in which my child participates to obtain on behalf of my child, in my absence, any necessary emergency medical services which may be required as a result of any injury to my child in connection with such participation (including travel incident thereto). I give permission to the physician selected by the school officials to hospitalize, secure proper treatment, order injections, anesthesia, or surgery for my child in the event of any emergency if cannot be immediately reached by phone or otherwise.
4. I agree with all expenses, other than that which is covered by Tattnall County High School's supplemental insurance, relating to or arising out of any such injuries or loss of life will be my financial responsibility, and my child and I agree to release, hold harmless and indemnify Tattnall County High School and its officers, employees, and trustees against any and all claims, liabilities, damages, and expenses, including reasonable attorney's fees, with respect to any injuries, regardless of severity, or loss of life relating to or arising out of my child's participation in any such sport or activity. And,
5. The undersigned grants the representative from Optim Sports Medicine and its employee's parental consent for your child's pre-participation screening and assessment/treatment of your child's injuries that he/she may suffer during the school year. I consent to internet storage and delivery of this information to medical providers.

I/WE HAVE READ THIS ATHLETIC PARTICIPATION CONSENT FORM CAREFULLY AND UNDERSTAND ITS CONTENTS

Parent/ Guardian Signature: _____ Date: _____

Georgia High School Association
Student/Parent Sudden Cardiac Arrest Awareness Form

SCHOOL: Tattnall County High 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 Tattnall County ***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 2025-2026 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: 3/25)

Georgia High School Association
Student/Parent Concussion Awareness Form

SCHOOL: Tattnall County High 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 Tattnall County ***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 2025-2026 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: 3/25)

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 _____

optim sports medicine

PATIENT FOCUSED • PHYSICIAN OWNED

PARENT/GUARDIAN CONSENT & RELEASE FORM

In order to provide the best possible medical care for your child, a medical record will be established for him/her. If your child should become injured while playing sports, this form will provide important information to coaches and medical personnel. Please complete and sign as indicated.

EMERGENCY CONTACT INFORMATION

Student's Name (Legal)_____, _____, _____
LAST FIRST MI

Student's Preferred Name _____ **D.O.B.**____/____/____ **Current Class** (circle one): 6th 7th 8th Fr So Jr Sr **HS Graduation Year: 20**____

Address: _____, **GA** _____
Street City Zip

Student's Home Phone #:(____) ____-____ **Student's Cell Phone #:**(____) ____-____

Child Lives With: ___ Father ____ Mother ____Both ____Other: _____

Father/Guardian's Name: _____ Employer: _____

Father/Guardian's Cell Phone #: (____) ____-____ Work Phone # (____) ____-____ext____

Mother/Guardian's Name: _____ Employer: _____

Mother/Guardian's Cell Phone #: (____) ____-____ Work Phone # (____) ____-____ext____

Parent/Guardian Contact E-Mail Address: _____

Emergency Contact (must be 21 or older): _____Relationship:_____

Contact Home Phone #: (____) ____-____ Contact Cell Phone # (____) ____-____ext____

Primary Physician: _____ Office Phone # (____)____-____ext ____

INSURANCE INFORMATION

Primary Insurance Co: _____ **Name of Policy Holder:**_____

Policy #: _____ **Group #:** _____

Customer Service Phone #: _____ **ext** _____

PLEASE BE AWARE OF THE FOLLOWING WHEN CARING FOR MY CHILD

Medical Conditions: _____

Allergies: _____

Medications & Condition: _____

PERMISSION FOR AUTHORIZATION TO TREAT IN PARENT'S ABSENCE

*I give permission for school representatives to authorize medical treatment for my child in my absence. This may include, but is not limited to, activation of emergency services, emergency room procedures, and injury/illness evaluation treatment by certified athletic trainers at away competitions.

Print Parent Name:_____ **Parent Signature:**_____

Date: _____/_____/_____

Please complete/sign/date every line (if applicable) in order for your student athlete to be eligible to participate.

ATHLETIC TRAINING & COMPETITION PARTICIPATION: Parental Consent and Insurance Information.

Warning: Although participation in supervised interscholastic athletics and school activities may be one of the least hazardous in which students will engage in or out of school, **BY ITS NATURE, PARTICIPATION IN INTERSCHOLASTIC ATHLETICS AND SCHOOL ACTIVITIES INCLUDES RISK OF INJURY, WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CATASTROPHIC INJURY, INCLUDING PERMANENT PARALYSIS FROM THE NECK DOWN OR DEATH.** Although serious injuries are not common in supervised school athletic programs or the school setting, it is possible only to minimize, not eliminate, risk.

Students can and do have responsibility to help reduce the potential for injury. **STUDENTS AND PLAYERS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR TEACHERS/COACHES, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR EQUIPMENT DAILY.**

By signing this consent form, you acknowledge that you have read and understand this warning. **PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THE FORM.**

I/We hereby give consent for my/our child to:

1. Compete in athletics in the Georgia High School Association.
2. Accompany any school team/activity on any of its local or out-of-town trips.
3. Verify that the information on this form is correct and understand that any false information may result in my son/daughter being declared ineligible to participate.

I further acknowledge and consent to the Internet storage and delivery of this information by Optim Sports Medicine and its affiliated vendors to medical providers, as appropriate.

This acknowledgement of risk and consent to allow participation shall remain in effect until revoked in writing.

Authorization to Release Medical Information

I, being of lawful age, hereby authorize and consent to having Optim Sports Medicine Program Athletic Trainers and/or their consulting physician(s) provide any requested medical information to other physicians, healthcare providers, high school coaches or school administration, intercollegiate teams, professional teams, scouts, recruiters, or athletic trainers that directly pertains to my participation at _____. Said authorization to release medical information will include, but is not limited to, information concerning illnesses, injuries, treatments, hospitalizations, examinations, X-rays, or other forms of diagnostic testing occurring while participating in activities at said school or athletic organization.

I understand that I may revoke this authorization by providing written notice to Optim Sports Medicine. I also understand that I am authorizing access to the student's medical records and patient identifiable information by executed this release.

This authorization shall be valid for one (1) year commencing on the effective date executed below. I understand that the release of my medical information is being carried out with my consent and so assume full responsibility.

MEDICAL CONSENT TO TREAT

I hereby grant parental consent to Optim Sports Medicine for assessment/treatment of any injuries my child may suffer during the school year in the course of athletic training or competition.

I give permission for school officials, chaperones, or representatives of Optim Sports Medicine overseeing the athletic training or competition in which my child is participating to seek medical aid and render first aid if such attention is necessary, at the sole discretion of such individual. In case of emergency and when I cannot be immediately reached by telephone or otherwise, I give permission to the physician selected by school officials to hospitalize, secure proper treatment, and order injections, anesthesia, or surgery for my child. I agree to be responsible for all medical expenses incurred in connection therewith. In the event the school incurs expenses for medical treatment, I agree to reimburse school in full.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTOOD THE ABOVE.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Print Name **Relationship to Student**

■ 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: _____

■ 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: _____

_____

_____