THE WILSON ACADEMY ATHLETIC PARTICIPATION FORM

FORM MUST BE COMPLETED PRIOR TO STUDENT PARTICIPATION IN ATHLETICS

CONTACT INFORMATION

Student Name:_____ **School Year:**_____ **SPORT(s)**_____

Home Address:_____

Name of Parent/Guardian(s):_____

Address (if different from above):_____

Mother: (Home Phone): (_____) _____-_____ **(Cell):** (_____) _____-_____

Father: (Home Phone): (_____) _____-_____ **(Cell):** (_____) _____-_____

IN CASE OF EMERGENCY, CONTACT:

Name:_____ **Relationship:**_____

(Home) (_____) _____-_____) **(Cell)** (_____) _____-_____

Personal Physician:_____ **Phone:**_____

ALTERNATIVE TRANSPORTATION LIABILITY RELEASE

Initial:_____ The Wilson Academy is not always able to provide transportation for students to off campus extracurricular school activities. In cases when transportation is not provided by The Wilson Academy, as in the use of a school bus or charter bus, it is the responsibility of the student's parents/guardian to secure their student's attendance at such activities. The Wilson Academy, its officers, employees or agents shall not be responsible for any injury or loss arising out of a student's transportation to or from the off campus activity when such transportation is provided by parents, student, staff or any other party.

MEDIA RELEASE

Initial:_____ I hereby give my consent to all photographs, audio recordings, academic work and/or video recordings taken of me or my minor child by The Wilson Academy staff or their designee. I understand that any such photographs, audio recordings, academic work and/or video recordings become the property of the local school or district and may be used by the school, district or others within their consent, for educational, instructional or promotional purposes determined by the district in broadcast and electronic media formats now existing or in the future created.

TRANSCRIPT WAIVER

Initial:_____ I give The Wilson Academy permission to release copies of my son's/daughter's official transcripts and test scores as needed for athletic and academic purposes. College recruiters will use this information to determine academic readiness for prospective athletes. Furthermore, in signing this you give permission to The Wilson Academy to transmit mentioned documents via fax or e-mail.

If you choose not to initial here, prospective colleges will not be given academic information that may help your son/daughter acquire a scholarship.

ATHLETIC CODE OF CONDUCT

Initial:_____ The Wilson Academy's' athletic programs are a great source of pride to our communities. Involvement in athletics helps students develop a better sense of responsibility, cooperation; self-discipline, self-confidence, and sportsmanship that will help serve them long after graduation. The lessons and values learned by participating on athletic teams last a lifetime.

All athletes are expected to abide by the highest standards of fair play and sportsmanship while on the court or field. We also have high expectations regarding behavior when the students are not engaged in athletic competitions. Students participating in our extracurricular athletic activities act as representatives of The Wilson Academy. All students are expected to conduct themselves in such a manner as to meet the standards of The Wilson Academy at all times. I understand the potential consequences that go along with violating the Athletic Code of Conduct, which include but are not limited to denial of athletic participation.

PERMISSION TO TREAT

Initial: _____ I give my permission for the coaches, certified athletic trainers and/or their designees to administer treatment for illness, injury or rehabilitation.

Initial: _____ In the event of an emergency and I cannot be reached, I grant permission to the school personnel, coaches and/or certified athletic trainers to activate the Emergency Action Plan.

PLEASE SIGN HERE:

THIS SIGNATURE CONSENTS TO TRANSPORTATION LIABILITY, MEDIA RELEASE, CODE OF CONDUCT, PERMISSION TO TREAT, ATHLETIC PARTICIPATION, TRANSCRIPT WAIVER, VERIFICATION OF INSURANCE COVERAGE AND MEDICAL AUTHORIZATION. THIS SIGNATURE ALSO REPRESENTS THAT ALL INFORMATION PROVIDED IN THIS ATHLETIC PARTICIPATION FORM IS ACCURATE AND COMPLETE.

_____ Signature of Athlete

_____ Signature of Parent/Guardian

_____ Date

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

DATE OF EXAM: _____ **SPORT(S):** _____

NAME: _____ **DATE OF BIRTH:** _____

MALE ____ **FEMALE** ____ **AGE** _____ **GRADE** _____ **SCHOOL:** _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

_____

Do you have any allergies? □ Yes □ No **If yes, please identify specific allergy below:**

□ Medicines_____ □ Pollens _____ □ Food_____ □ Stinging Insects _____

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: □ Asthma □ Anemia □ Diabetes □ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: □ High blood pressure □ A heart murmur □ High cholesterol □ A heart infection □ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**Yes**	**No**
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "YES" answers here

_____

_____

_____

_____

_____

_____

_____

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

_____ _____ _____

SIGNATURE OF ATHLETE **SIGNATURE OF PARENT/GUARDIAN** **DATE**

PHYSICAL EXAMINATION FORM /CLEARANCE 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, 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 supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seatbelt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height	Weight	□ Male □Female	
BP / (/)	Pulse	Vision R20/ L20/	Corrected □ Y □ N
MEDICAL		**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span >height, hyperlaxity,myopia, MVP,aortic insufficiency)			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart a • Murmurs (auscultation standing, supine, +/-Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary(males only)b			
Skin • HSV,lesions suggestive of MRSA, tinea corporis			
Neurologic c			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

A Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
B Consider GU exam if in private setting. Having third party present is recommended.
C Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion

□ **Cleared for all sports without restriction**

□ **Cleared for all sports without restriction with recommendations for further evaluation or treatment for**

_____

□ **Not Cleared ……..□ Pending further evaluation ……□ For any sports ……..□ For certain sports**

Reason _____

Recommendations _____

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

PHYSICIAN NAME (PRINT/TYPE/STAMP):_____ **Medical Designation (MD/DO/PA/APN/CPN,etc):**_____

ADDRESS:_____**CITY** _____ **STATE** _____**ZIP** _____

SIGNATURE OF PHYSICIAN _____ **EXAM DATE** : _____

PARENTAL CONSENT FOR ATHLETIC PARTICIPATION

WARNING

- Although participation in supervised interscholastic athletics and activities may be one of the least hazardous in which students will engage, **BY ITS NATURE, PARTICIPATION IN INTERSCHOLASTIC ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG TERM CATASTROPHIC, INCLUDING PERMANENT PARALYSIS FROM THE NECK DOWN OR DEATH.** Although serious injuries are not common in supervised school athletic programs, it is possible only to minimize, not eliminate the risk.
- Participants can and have the responsibility to help reduce the chance of injury. **PLAYERS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACHES, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR EQUIPMENT DAILY.**
- By signing this permission 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 THIS PERMISSION FORM.**

I (we) hereby give consent for _____ to:

(1) Compete in athletics at The Wilson Academy;
(2) To accompany any school team of which the student is a member on any of local or out of town trips;
(3) and I hereby verify that information included on this form is correct and understand that any false information may result in my son/daughter being declared ineligible.

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

INSURANCE INFORMATION

Please INITIAL ONE of the following statements regarding insurance coverage for your son/daughter for the _____ school year.

_____ My son/daughter is adequately and currently covered by accident insurance that will cover injuries sustained while participating in interscholastic athletes (including, but not limited to, varsity, junior varsity and 9th grade competition).

_____	_____	_____
Company providing insurance	**Name of insured**	**Policy#**

_____

MEDICAL AUTHORIZATION

I certify that the medical history on this form is complete and accurate. I understand that this will serve as the basis for determining that my child, _____, may compete in athletics with The Wilson Academy. I also understand that this medical evaluation is only to determine fitness for athletics and is not to take the place of regular medical examinations. In case of an emergency or accident on the school grounds or during any school activity involving my child, _____, which in the opinion of school authorities present requires immediate medical or surgical attention, I hereby grant permission to physicians, consulting physicians, certified athletic trainers, emergency medical technicians, and other healthcare providers selected by school authorities to provide medical care and treatment (including hospitalization if deemed appropriate by school authorities or an appropriate healthcare provider) unless I am present and request otherwise or until I later request otherwise.

Student/Parent Concussion Awareness Form **SCHOOL:** THE WILSON ACADEMY

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 The Wilson Academy 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 2019-20 school year. This form will be stored with the athletic physical form and other accompanying forms required by The Wilson Academy.

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***