GEORGETOWN COUNTY SCHOOL DISTRICT

ATHLETIC PRE-PARTICIPATION FORM

Dear Parent/Guardian

In order to ensure efficient and appropriate health care for your child, we must ask you to complete several forms before allowing your child to participate in interscholastic athletics or extracurricular activities. It is extremely important that no parts of the form be left blank. Incomplete forms will not be accepted.

If you should have any questions or concerns about this process, please do not hesitate to contact the Athletic Trainer at your child's high school.

ALL FORMS MUST BE COMPLETED AND RETURNED TO THE ATHLETIC TRAINING ROOM AT YOUR CHILD'S SCHOOL BEFORE YOUR CHILD WILL BE ALLOWED TO PARTICIPATE IN ANY TRY-OUT, PRACTICE, OR GAME.

Please follow the directions below for completing the attached physical forms . . .

1. Parent / Guardian and student athlete read, sign, and date the "HIPPA Form".
2. Parent / Guardian and student athlete complete "Student Athlete Information" form.
3. Parent / Guardian complete, sign, and date the "Authorization for Release of Medical Information" form.
4. Parent / Guardian and student athlete read, sign, and date "Parent / Guardian Consent Waiver, and Medical Release Form for Athletics".
5. Parent / Guardian and student athlete read, sign, and date the "Mild Traumatic Brain Injury (MTBI) / Concussion Annual Statement and Acknowledgement Form for Student Athletes"
6. Completely fill out the "Pre-participation Health Screening for Athletes / Extracurricular Activities" form, then sign and date it at the bottom. It is extremely important that no parts of the form be left blank. Incomplete forms will not be accepted.
7. Take the forms to your doctor and have them complete the physical examination portion of the physical form.

NOTE: Physical forms MUST be signed by a licensed medical doctor in South Carolina or a Certified Physician's Assistant or Family Nurse Practitioner practicing under the supervision of a licensed South Carolina MD or DO. Chiropractor signatures are NOT valid.

Pre-participation physicals are valid from April 1, 2024 – June 30th, 2025.

Tidelands Health Sports Institute
Disclosure Authorization Privacy Practices
HIPAA Form

I, _____(student's name) and my parents / legal guardians / adult responsible for my care _____ parents / legal guardian /adult responsible-circle one applicable) hereby authorize Tidelands Health and its athletic trainers to disclose to the Georgetown County School System, coaches, athletic staff and any other person involved in the operation, administration or management of the Georgetown County Board of Education sanctioned extracurricular sports programs at area district schools, as well as student's parents/legal guardians/adult responsible, any medical or health information relevant to student's involvement or participation in such extracurricular sports programs. Such disclosure shall be for the purpose of communicating student's ability to participate or continue participation in an extracurricular sports program, including whether student has suffered any injury, the extent of such injury, the impact such injury could make on continued participation, whether student's condition requires further treatment, and whether there should be any adjustment to student's participation in such extracurricular sports programs in the Georgetown County School System. This authorization shall terminate when the season for the extracurricular sports program in which student is participating ends, including any post-season (e.g. tournament) play. This authorization also continues through each sport (multiple sports) that the student may play. The undersigned have the right to revoke this authorization at any time by providing the Tidelands Health Compliance Officer notice in writing. Exceptions to this right of revocation and a description of how this authorization may be revoked are contained in the Tidelands Health Notice of Privacy Practices. Tidelands Health's athletic trainers will not condition treatment on whether this authorization is signed; however, the Georgetown County School System will not permit any student to participate in any extracurricular sports games or tournament play attended by an athletic trainer if the student and his/her parents/legal guardians/adult responsible have not signed an authorization. The undersigned understands and agrees that medical or health information disclosed by Tidelands Health or its athletic trainers pursuant to this authorization may be subsequently disclosed by the recipient and may no longer be protected by applicable law.

In addition to the foregoing, the undersigned hereby acknowledges receipt of Tidelands Health Notice of Privacy Practices.

_____ _____

Student's Signature Date

_____ _____

Parent / Legal Guardian / Responsible Adult Date

Student Athlete Information

Name _____ **Sex (circle):** M F

Current Grade (circle) 7 8 9 10 11 12 **Date of Birth** _____ / _____ / _____
Month Day Year

Mailing Address _____ **City** _____

Zip _____ **Home Phone** _____ **Cell Phone** _____

Email _____

Parent / Guardian Information

Father _____ **Home Phone** _____ **Cell Phone** _____

Email _____

Employer _____ **Work Phone** _____

Mother _____ **Home Phone** _____ **Cell Phone** _____

Email _____

Employer _____ **Work Phone** _____

Emergency Contact _____ **Phone** _____ **Alternate** _____

Healthcare Information

Family Doctor _____ **Phone** _____ **Alternate** _____

Is this student covered by private healthcare, medical insurance, and / or Medicaid? _____ Yes _____ No

Medicaid Provider _____ **Medicaid Number** _____

Name of private healthcare / medical insurance provider _____

Policy Holder's Name _____ **Social Security Number** _____-_____-_____.

Group Name _____ **Group #** _____ **Policy #** _____

School Attending

_____ Andrews HS _____ Carvers Bay HS _____ Carvers Bay MS _____ Georgetown HS _____ Georgetown MS

_____ Rosemary HS _____ Waccamaw HS _____ Waccamaw IMS _____ Waccamaw MS

GEORGETOWN COUNTY SCHOOL DISTRICT

Authorization for Release of Medical Information: 2024-2025 *(Note: This form must be completed signed, and returned to school with physical)*

Student's Name _____ **Date of Birth** ____ / ____ / _____.

Current Grade (circle) 7 8 9 10 11 12

I hereby authorize Georgetown County Schools to obtain, use, and disclose my child's protected health information ("Health Information") as defined by Federal and state law, in the manner described below. I understand that this authorization is voluntary. I also understand that if the person or entity authorized by this document to provide or receive my child's Health Information is not a health plan or health-care provider, then the disclosed Health Information may no longer be protected from further disclosure by federal or state law. Any and all of the following health information may be obtained, used, or disclosed by Georgetown County Schools

Please Check the Appropriate Box

□ All records, including those listed below

□ Pre-participation physical forms only

□ Medical records only

□ Insurance claims, medical billing and / or Medicaid information only

This information may be obtained from, used by / for, or disclosed to, the following individual(s) and / or entities.

□ All of the individuals / entities listed below

□ Affiliated team physicians only

□ Affiliated allied health care providers such as physical therapists, counselors, etc. only

□ Family physician only – Physician's Name(s): _____

□ School athletic insurance policy provider only

□ Primary insurance policy provider only

□ Another school(s) in the event of a student transfer only

□ Other, please list the contact information here:
Name _____
Address _____
Telephone # _____

I understand that my child's healthcare will not be affected if I do not sign this form. This authorization shall expire one year from the date of my signature below. I understand that I may revoke this authorization at any time by notifying Georgetown County Schools in writing. I understand that my revocation of this authorization will not affect any actions taken by Georgetown County Schools in reliance on this authorization prior to the time it received my revocation. I understand that I have a right to receive a copy of this authorization.

Signature: _____ **Date:** _____

Relationship to student listed above (please check one) □ Parent □ Legal Guardian

Note: A photocopy or facsimile of this document shall be considered the same as the original document

GEORGETOWN COUNTY SCHOOL DISTRICT

Parent / Guardian Consent, Waiver, and Medical Release Form for Athletics: 2004-2025 *(Note: This form must be completed signed, and returned to school with physical)*

Student's Full Name _____ **Date of Birth** _____ / _____ / _____.

School _____ **Home Phone** _____

Parent / Guardian _____ **Phone** _____

I hereby give permission for the above-named student to participate in the interscholastic athletic program beginning the date I acknowledge that my consent is valid through June 30, 2025, and to travel on athletic trips scheduled for his/her team(s) until that date. In granting this permission, I assume full responsibility for the behavior of my child and for any and all damages to person or property caused by my child.

As a parent or legal guardian of the above-named student athlete, I give permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular healthcare. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers, and coaches as well as physicians or those under their direction who are part of the athletic injury prevention and treatment, to have access to necessary medical information. I know the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

I understand that participation in athletics is a privilege and an opportunity for my child. In that regard, I agree that if it is determined that my child needs medical or dental treatment as the result of athletic participation and incurs resulting costs and those costs are not otherwise covered, it ultimately is my financial responsibility to cover the cost of any treatment provided by a physician, dentist, athletic trainer, emergency medical personnel, or any other medical personnel.

I give my permission for the school district's sports medicine staff to care for and provide appropriate medical treatment for my child in the event of his/her injury.

I agree to notify the athletic trainer immediately in writing of any changes in my child's health which requires modification to my permission. My child and I understand that all school related athletic injuries are to be reported to the Certified Athletic Trainer at their school as soon as possible.

I understand that by participating in interscholastic athletics, including practices, my child is exposing himself/herself to the risk of serious injury and death. By my signature below I release and waive, and further agree to indemnify, hold harmless or reimburse the Georgetown County School District, the individual members, employees, representatives, and agents thereof, from and against, any claim which I, any other parent or guardian, any sibling, my child, or any other person, firm, or corporation may have or claim to have, known or unknown, directly or indirectly, for any losses, damages, injuries, or adverse reactions arising out of, during, or in connection with my child's participation in athletic competition(s) and/or practice(s) and in connection with the administration of medication(s) to my child as specified above. I agree that a photocopy or facsimile of this document shall be considered the same as the original document.

I HAVE READ AND UNDERSTAND THIS RELEASE AGREEMENT AND THE "INFORMATION CONCERNING PARTICIPATION IN SPORTS" PRESENTED WITHIN THIS RELEASE AGREEMENT. MY CHILD AND I HAVE DISCUSSED THE RISKS INHERENT IN PLAYING (indicate sports) AND WE HAVE AGREED THAT WE WISH TO ASSUME THAT RISK.

Signature or Student Athlete _____ **Date** _____

Signature of Parent / Guardian _____ **Date** _____

Pre-participation physicals are valid from April 1, 2024 – June 30th, 2025.

GEORGETOWN COUNTY SCHOOL DISTRICT

Mild Traumatic Brain Injury (MTBI) / Concussion Annual Statement & Acknowledgement Form for Student Athletes: 2024-2025 *(Note: This form must be completed signed, and returned to school with physical)*

I _____ (student), acknowledge that I have to be an active participant in my own health and have the direct responsibility for reporting all of my injuries and illnesses to the appropriate school staff (i.e. coaches, athletic training staff, and school nurse). I further recognize that my physical condition is dependent upon providing an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, and / or disabilities experienced before, during or after athletic activities.

By signing below, I / We Acknowledge:

- My school has provided me with specific educational materials including the CDC Concussion fact sheet (http://www.cdc.gov/concussion/HeadsUp/youth.html) on what a concussion is and has given me an opportunity to ask questions.
- I/We have fully disclosed to the school medical staff any prior mild traumatic brain injuries (MBTI) / concussions and will also disclose any future conditions.
- There is a possibility that participation in my sport may result in a head injury and / or concussion. In rare cases, these concussions can cause permanent brain damage, and even death.
- A concussion is a brain injury, which I/We am/are responsible for reporting to the coach, athletic trainer, school nurse, or other appropriate school medical staff member.
- A concussion can affect my ability to perform everyday activities, and affect my reaction time, balance, sleep, and classroom performance.
- Some of the symptoms of concussion may be noticed right away while other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I will make every effort to report the injury to the appropriate school staff and / or school medical staff member.
- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
- I will not return to play in a game or practice until my symptoms have resolved and I have written clearance to do so by a qualified health care professional.

I represent and certify that I and my parent/guardian have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be bound by this document.

Student Athlete must print their name and sign / date below

_____	_____	_____
Print Name	**Signature**	**Date**

Parent / Guardian must print their name and sign / date below

_____	_____	_____
Print Name	**Signature**	**Date**

Georgetown County School District
Pre-Participation Health Screening for Athletes / Extracurricular Activities

Name _____ **Sex (circle):** M F

Current Grade (circle) 7 8 9 10 11 12 **Date of Birth** _____ / _____ / _____

Sports you plan to play (check) _____ Football _____ Basketball _____ Baseball _____ Softball _____ Volleyball

_____ Wrestling _____ Cross Country _____ Soccer _____ Track _____ Swimming _____ Golf _____ Lacrosse

_____ Cheerleading _____ Tennis _____ NJROTC _____ Dance Team _____ Other (list)_____

Medical History (Answer all questions by checking the "yes" or "no" boxes. Explain all "yes" answers in the space below

General Medical History		**Yes**	**No**	**Unsure**
1	HAVE YOU HAD ANY MEDICAL PROBLEM OR PHYSICAL INJURY SINCE YOUR LAST PHYSICAL EXAM?	☐	☐	☐
2	DO YOU HAVE ASTHMA?	☐	☐	☐
3	DO YOU HAVE DIABETES?	☐	☐	☐
4	DO YOU HAVE HIGH BLOOD PRESSURE?	☐	☐	☐
5	DO YOU HAVE SEIZURES?	☐	☐	☐
6	DO YOU HAVE SICKLE CELL TRAIT?	☐	☐	☐
7	HAVE YOU HAVE ANY OTHER MAJOR MEDICAL PROBLEM?	☐	☐	☐
8	HAVE YOU EVER BEEN HOSPITALIZED OR HAD SURGERY?	☐	☐	☐
9	DO YOU COUGH, WHEEZE, OR HAVE TROUBLE BREATHING WHEN EXERCISING?	☐	☐	☐
10	DO YOU USE AN INHALER?	☐	☐	☐
11	DO YOU HAVE A SINGLE ORGAN (TESTICLE OR KIDNEY)?	☐	☐	☐
12	ARE YOU CURRENTLY TAKING ANY MEDICINES OR DO YOU TAKE ANY MEDICINES ON A REGULAR BASIS (PRESCRIPTION OR OVER-THE-COUNTER)?	☐	☐	☐
13	HAVE YOU EVER TAKEN ANY SUPPLEMENTS OR VITAMINS TO HELP WITH WEIGHT LOSS, WEIGHT GAIN, OR TO IMPROVE PERFORMANCE?	☐	☐	☐
14	DO YOU HAVE ANY ALLERGIES (SEASONAL, INSECTS, FOOD, OR MEDICINES)?	☐	☐	☐
15	HAVE YOU EVER HAD A RASH OR HIVES DEVELOP DURING OR AFTER EXERCISE?	☐	☐	☐
16	DO YOU HAVE ANY SKIN PROBLEMS OTHER THAN ACNE?	☐	☐	☐
17	HAVE YOU EVER HAD A HEAD INJURY, BEEN KNOCKED OUT, LOST YOUR MEMORY, HAD YOUR "BELL RUNG", OR A CONCUSSION?	☐	☐	☐
18	HAVE YOU EVER HAD NUMBNESS OR TINGLING IN YOUR ARMS, HANDS, LEGS, OR FEET?	☐	☐	☐
19	HAVE YOU EVER HAD A "STINGER", "BURNER", OR PINCHED NERVE?	☐	☐	☐
20	HAVE YOU EVER BECOME ILL FROM EXERCISING IN THE HEAT?	☐	☐	☐
21	HAVE YOU HAD MONONUCLEOSIS OR ANY SIGNIFICANT ILLNESS IN THE LAST 60 DAYS?	☐	☐	☐
22	DO YOU HAVE TROUBLE WITH YOUR EYES/VISION/WEAR GLASSES OR CONTACTS?	☐	☐	☐
23	DO YOU HAVE TROUBLE WITH YOUR HEARING/WEAR HEARING AIDS?	☐	☐	☐
24	DO YOU WANT TO WEIGH MORE OR LESS THAN YOU DO NOW?	☐	☐	☐
25	DO YOU LOSE WEIGHT REGULARLY TO MEET WEIGHT REQUIREMENTS FOR YOUR SPORT OR OTHER REASONS	☐	☐	☐
26	DO YOU FEEL STRESSED OUT, OVERLY TIRED, OR DEPRESSED?	☐	☐	☐
27	ARE THERE ANY OTHER ISSUES YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR?	☐	☐	☐

Cardiac History				
1	HAVE YOU EVER PASSED OUT DURING OR AFTER EXERCISE?	☐	☐	☐
2	HAVE YOU EVER HAD UNEXPLAINED DIZZINESS DURING OR AFTER EXERCISE?	☐	☐	☐
3	HAVE YOU EVER HAD CHEST PAIN OR CHEST PRESSURE DURING OR AFTER EXERCISE?	☐	☐	☐
4	DO YOU TIRE EASILY OR MORE QUICKLY THAN YOUR FRIENDS DURING EXERCISE?	☐	☐	☐
5	HAVE YOU EVER HAD RACING OF YOUR HEART OR SKIPPED HEART BEATS?	☐	☐	☐
6	HAVE YOU EVER BEEN TOLD THAT YOU HAVE A HEART MURMUR?	☐	☐	☐

7	HAVE YOU EVER BEEN TOLD THAT YOU HAVE AN ENLARGED HEART?	ڤ	ڤ	ڤ
8	HAS A PHYSICIAN EVER ORDERED ANY TESTING FOR YOU HEART?	ڤ	ڤ	ڤ
9	HAS A PHYSICIAN EVER DENIED OR RESTRICTED YOUR PARTICIPATION IN SPORTS?	ڤ	ڤ	ڤ
10	HAS ANY MEMBER OF YOUR FAMILY DIED OF HEART PROBLEMS OR SUDDEN DEATH BEFORE AGE 50?	ڤ	ڤ	ڤ
11	HAS ANY MEMBER OF YOUR FAMILY BEEN TOLD THEY HAD A SERIOUS HEART PROBLEM BEFORE AGE 50?	ڤ	ڤ	ڤ
12	HAS ANY MEMBER OF YOUR FAMILY BEEN TOLD THEY HAD MARFAN'S SYNDROME, ARRYTHMIA, CARDIOMYOPATHY, LONG-QT SYNDROME, ION CHANNELOPATHIES, OR CARDIAC CONDITIONS?	ڤ	ڤ	ڤ

Orthopedic History

1	HAVE YOU EVER BROKEN OR FRACTURE ANY BONES?	ڤ	ڤ	ڤ
2	HAVE YOU EVER DISLOCATED OR PARTIALLY DISLOCATED ANY JOINT?	ڤ	ڤ	ڤ
3	HAVE YOU HAD ANY PROBLEMS RELATED TO YOUR: ڤ NECK, SPINE, OR BACK ڤ SHOULDERS ڤ ELBOWS ڤ WRISTS, HANDS, OR FINGERS ڤ HIPS ڤ KNEES ڤ ANKLES, FEET, OR TOES ڤ OTHER	ڤ	ڤ	ڤ

Females Only

1	ARE YOUR PERIODS REGULAR (EVERY MONTH)?	ڤ	ڤ	ڤ
2	ARE YOUR PERIODS HEAVY?	ڤ	ڤ	ڤ
3	WHEN WAS YOUR FIRST PERIOD? MONTH _____ YEAR _____ .	ڤ	ڤ	ڤ
4	WHEN WAS YOUR LAST PERIOD? MONTH _____ YEAR _____ .	ڤ	ڤ	ڤ

Please explain "Yes" answers from the above below

_____

_____

_____

Signature of Parent / Guardian _____ **Date** _____

Note: A photocopy or facsimile of this document shall be considered the same as the original document

Pre-participation physicals are valid from April 1, 2024 – June 30th, 2025.

Pre-Participation Health Screening Examination

Name _____ **Date of Birth** ____ / ____ / _____. **Age** ____

Height _____ Weight _____

Pulse _____ BP _____ / _____. Respiration _____

Vision _____ Corrected (circle): Yes No If yes, with? (circle) Glasses / Contacts

Musculoskeletal	**Normal**	**Abnormal Findings**	**Initials**
Neck			
Shoulders			
Elbows			
Wrists			
Hands			
Back / Spine			
Hip / Pelvis			
Knees			
Ankles			
Feet			

Musculoskeletal Provider Signature _____ **Date** _____

Systems	**Normal**	**Abnormal Findings**	**Initials**
Cardiopulmonary			
Pulses (including femoral)			
Heart (supine & squat to standing)			
Lungs			
Skin			
Abdominal			
Genitalia			
Physical Stigmata of Marfan Syndrome			

Dental Examination	**Normal**	**Abnormal Findings**	**Initials**
Gums & Tongue			
Teeth			
TMJ Joint			

Clearance □ Cleared

□ Cleared after completing evaluation / treatment for _____

□ Not cleared for sport / activity _____

Other Recommendations _____

Examining Physician Signature: _____ **Date** _____

Pre-participation physicals are valid from April 1, 2024 – June 30th, 2025.