HERITAGE MIDDLE SCHOOL
Athletic Check Sheet

Phone: 706-937-3568
Fax: 706-937-2483

Melissa Butler, Principal
Bobby Davis, Athletic Director

I, the undersigned, do hereby give my permission for _____ to participate in Heritage Middle School Athletics during the 20____ school year. I have read, understand, and comply with all forms attached. Please initial all that apply and return this page to your coach:

I have read and understand the following and have submitted the following forms:

_____ Students must meet grade eligibility requirements (No Pass-No play). They must pass at least 5 of 6 classes (semester by semester)

_____ Insurance and Medical Form / Medical Information Release

_____ Catoosa County Athletic Rules and School Conduct (2 pages)

_____ Physical form (good for 1 calendar year) (4 pages)

_____ Concussion Awareness and Management Form (I have read the forms and I understand the facts presented in it.)

_____ Heat Policy (I have read it and understand the facts presented in it.)

_____ Field Trip Waiver (I give my student, listed above, permission to travel with the team listed above.)

_____ Emergency Medical Treatment Authorization (I give permission for the treatment of my child listed above.)

_____Cardiac Arrest Awareness Form (I have read the form and understand the facts presented in it.)

_____ _____

Parent/Guardian Date

Heritage Middle School
Insurance and Medical Form

_____ _____ _____
First Name Middle Name Last Name

Birthday: _____ Grade: _____ Gender: Male/Female

Warning Form and Insurance Statement

Permission is given for _____to participate in organized middle school athletics, realizing that such activity involves the potential for injury which is inherent in all sports. It is understood that one requirement of eligibility for athletic participation is adequate insurance coverage against injury while in practice or performance.

Student is adequately covered with such accident insurance policies, which parent carries.

_____
(Name of Insurance Company)

We have purchased the insurance plan offered by the school. (**See important information)
Yes_____ No____

_____ _____
(Signature of Parent or Legal Guardian) **(Date)**

Please notify HMS if your insurance status changes.

****Important Information: Catoosa County Schools does not have accident or health insurance coverage on students. If you do not have private healthcare/accident coverage, please consider purchasing the policy available to your child at the beginning of every school year at a very reasonable cost. You may purchase Student Insurance online at: http://www.studentinsurance-kk.com**

Revised 2/4/2014

Medical Information Release

In accordance with new health information guidelines we are required to ask you to make a decision on the following information below and let the school know of your choice.
"Medical information concerning my child will be released to medical and school personnel who need that information (emergency medical personnel, school nurse, teachers, etc). If you desire to withhold or restrict the release of medical information regarding your child, you must notify the school athletic director in writing. Your signature on this form acts as the authorization to so release this medical information."

_____ _____
(Signature of Parent or Legal Guardian) **(Date)**

Revised 2/4/2014

Catoosa County Athletic Rules

I,_____ understand that participation in an athletic program at a

Catoosa County School is a privilege and not a right: therefore, I understand and agree to be held to a higher standard of conduct and dress than a student who does not participate in athletics. I acknowledge that this higher standard of conduct will cover my actions at school, on the field and in the community. I will refrain from taking part in any activity that might reflect negatively on my school or team.

I understand that drugs and alcohol are harmful, and that all athletes in Catoosa County Schools are subject to drug/alcohol testing in accordance with Catoosa County Board of Education drug testing policy.

I recognize that the use of tobacco products is a major health risk and is prohibited by school policy; therefore, I agree not to use or possess tobacco products at <u>any time during the school year.</u>

I agree to dress tastefully and conservatively at all times because I represent my school to others. I know that all school rules are in effect during athletic practices and contests, but I also understand that there are additional **SPECIAL RULES** that are given by the coaching staff to make our team stronger. Infractions of these rules will become a part of the student's discipline record.

THESE SPECIAL RULES ARE:

DRUG/ALCOHOL

Possession or use of drugs or alcohol:

1st Violation: Minimum suspension of 20% of the regular season games. Before participation in another game, the student must submit a comprehensive drug test, at family's expense, that would indicate the presence and level of concentration of a full panel of drugs. This drug test should be negative of the presence of drugs, or in the case of marijuana, should reveal a declining concentration of the substance.

2nd Violation: Dismissal from the athletic program for a calendar year.

3rd Violation: Dismissal from participation in athletics permanently in Catoosa County.

Off Season violation of school drug/alcohol policy will be punished in the next season of participation.

Drug/alcohol offenses are cumulative throughout a student's high school career.

** All student drug and tobacco offenses should also be punishable under the Catoosa County Student Code of Conduct.

SCHOOL CONDUCT

Player assigned to In-School Suspension: (Definition: ISS begins the first day served. On the last day of ISS the suspension ends at 3:30p.m.)

1st Assignment: Minimum 1 game suspension. Middle School students will be suspended a min. of 1 game.

2nd Assignment: Minimum 3 games suspension. Middle School students will be suspended a Min. of 1 game

*Each additional assignment at the discretion of the school administration with the minimum described above.

Player assigned to Out-of-School Suspension:

1st Assignment: Minimum Suspension of 20% of the regular season games.

2nd Assignment: Dismissal from the athletic program for a calendar year.

*Students are allowed to practice while in ISS but cannot attend or participate in a game.

*Suspensions for games due to ISS/OSS are applicable only during the season.

TEAM CONDUCT

Unsportsmanlike behavior:

1st Offense: Extra running

2nd Offense: Punishment at coach's discretion.

Note: Any athlete ejected from a game is automatically suspended for the next 2 games by G.H.S.A. Middle School athletes will be suspended 1 game by N.G.A.C.

3rd Offense: Dismissal from the athletic program the remainder of the school year.

Note: Catoosa County School Board Policy does not allow any student to participate on any day he/she is tardy to school or absent from school unless approved by an administrator.

My signature below constitutes my agreement to comply with the rules of my school athletic program. I also understand that these are only the major rules and each sport may supplement these rules with others to govern other situations.

Signed:_____ Date:_____
Student

I, the parent or guardian of have read and understand the above rules. The signing of this document does not necessarily mean that I agree with all the rules contained within, but that I have read them and understand that my child will be required to follow them.

Signed:_____ Date:_____
Parent or guardian

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

SCHOOL: Heritage Middle 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 hypertrophi 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 CP 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 1C 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 Heritage Middle 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 2019-2020 school year. This form will be stored with the athletic physical form and other accompanying forms required by the*** Catoosa County ***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: 5/19)

Heritage Middle School

2014-15 Georgia High School Association

(Revised 7/14)

Student/Parent Concussion Awareness Form

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.)

BYLAW 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.

c) It is mandatory that every coach in each GHSA sport participate in a free, online course on concussion management prepared by the NFHS and available at www.nfhslearn.com at least every two years beginning with the 2013-2014 school year.

d) Each school will be responsible for monitoring the participation of its coaches in the concussion management course, and shall keep a record of those who participate.

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

Heritage Middle School
Heritage Athletics

4005 Poplar Spring Road
Ringgold, GA 30736

Phone: 706 937-3568
Fax: 706 937 2483

Parents or Guardians

This year, Heritage Middle School in conjunction with the Georgia High School Association (GHSA) has instituted a heat and humidity policy. The policy is designed to help protect student athletes in times of extremely high heat and humidity. The measuring device used is referred to as a Wet Bulb Globe Tester. This device takes into account air temperature, relative humidity and direct solar radiation on the body. It uses a complex math formula to calculate the WBGT reading. This reading is then digitally displayed for athletic and medical personal to see. Both our athletic staff and our athletic trainer will monitor and track the WBGT reading and record it.

The state has set guidelines to the practice lengths and rest periods for the athletes, given certain WBGT readings. Any WGBT reading that exceeds 92 degrees will render immediate stoppage of practice until the reading drops below 92. **Understand that a 92 on a WBGT and a 92 on a regular thermometer are not the same.**

It is our intentions to keep all athletes safe in every aspect of their participation in athletics here at Heritage Middle School and that every precaution is being taken to do so. Should you have any questions concerning this heat policy, please contact the athletic department.

Thank you,

Bobby Davis, Athletic Director

HERITAGE MIDDLE SCHOOL

Ringgold, Georgia 30736

FIELD TRIP WAIVER OF RESPONSIBILITY

Whereas, I (We) recognize that the trip is a voluntary educational opportunity. I (We) the parent(s) of legal guardian does grant him/her permission to travel with the chosen group of students under the supervision of the school board-approved chaperones of the school-board approved trip. I (We) agree not to hold responsible the chaperones, Heritage Middle School, its officers, or the County Board of Education for accidents, injuries, or illness of our child during this trip.

Permission is granted upon initialing front page of packet.

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

Please read the following statement closely. This form is mandatory for each athlete in our athletic program.

The undersigned hereby authorizes Heritage Middle School as our agent to give consent to surgical or medical treatment by any licensed physician or hospital in the state of Georgia for our child if/when such treatment is deemed necessary by such physicians and we cannot be reached within reasonable length of time.

Such consent may include, but is not limited to, transportation to a hospital emergency room, administration of necessary anesthetics, medical treatment, tests, x-ray, examination, transfusions, injections or drugs, and the performing of whatever operation may be deemed necessary or advisable. It is understood this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required.

Permission is granted upon initialing front page of packet.

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	☐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.)

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?	☐	☐
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.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

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: _____

_____

_____

PREPARTICIPATION PHYSICAL EVALUATION

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: _____ Date of birth: _____

1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "Yes" answers here.

_____

_____

_____

Please indicate whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (x-ray) evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

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: _____