

Name\_\_\_\_\_

GRADE FOR **2022/2023**: 5 6 7 8 9 10 11 12

FREDERICA ACADEMY PARENTAL CONSENT FOR  
PARTICIPATION IN ATHLETICS AND PHYSICAL EDUCATION COURSES

**WARNING:** Participation in interscholastic athletics and/or physical education courses at Frederica Academy includes risk of injury ranging in severity from minor to catastrophic, including permanent paralysis from the neck down or death. Although serious injuries are not common in supervised athletic activities, it is possible only to minimize, not eliminate, the risk. Participants have the responsibility to help reduce the chance of injury. Student-athletes must obey all safety rules, report all physical problems to their coaches/teachers, follow a proper conditioning program, and inspect their equipment/surroundings daily.

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

With full understanding of the risk involved, I/we release and hold harmless my child's school, it's employees, schools against which it competes, and contest officials of any and all responsibility and liability for injuries or claim resulting from such athletic participation. I/we agree to take no legal action against Frederica Academy because of any accident or mishap involving the athletic participation of my child.

I give consent for my student-athlete to:

- (1) Participate in physical education courses offered through the school curriculum.
- (2) Compete in athletics at Frederica academy, a member of the Georgia Independent School Association.
- (3) Accompany any school team of which my child is a member on any of its local or out-of-town trips using transportation designated by the school/coaches.
- (4) Have first aid and emergency medical treatment while under the supervision of Frederica Academy. In case of serious illness or injury, school personnel may call 911 for transport and emergency treatment at the nearest hospital.

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

SIGNATURE OF PARENT/GUARDIAN\_\_\_\_\_DATE\_\_\_\_\_

SIGNATURE OF  
STUDENT\_\_\_\_\_DATE\_\_\_\_\_

**AUTHORIZATION FOR ON-CAMPUS PRE-PARTICIPATION PHYSICAL EVALUATION (PPE):** I certify that the medical history provided to Frederica Academy is complete and accurate. I understand that this medical screening is only to determine fitness eligibility for athletics/physical education courses and is not to take the place of regular physical examinations. I also understand that this evaluation will serve as the basis for determining that my child may compete in school athletics. I release and hold harmless the screening physician, screening staff, and Frederica Academy as it pertains to this athletic screening.

SIGNATURE OF PARENT/GUARDIAN\_\_\_\_\_DATE\_\_\_\_\_

**HEALTH INSURANCE INFORMATION:**

Health Insurance Company\_\_\_\_\_Phone number\_\_\_\_\_

Insurance Policy number\_\_\_\_\_Group number\_\_\_\_\_

**Southeast Georgia Health System Consent to Treatment and Waiver of Liability Form**

I \_\_\_\_\_ [Name of Parent or Guardian] am the parent or legal guardian of \_\_\_\_\_ [Name of Student]. I understand that Southeast Georgia Health System (the "Health System") provides athletic training, first aid and certain other medical services in connection with certain athletic events and programs of Frederica Academy, including pre-participation physical examinations. In case of emergency or accident on the school grounds or during any school activity involving the above-name student, which in the opinion of school authorities or personnel of the Health System present requires immediate medical or surgical attention, I hereby grant permission to such school authorities and Health System personnel to render medical treatment and to obtain the services of qualified medical personnel to treat the condition unless I am present and request otherwise or until I later request otherwise. I also authorize that a pre-participation physical examination be conducted on student.

I hereby release and agree to hold harmless Frederica Academy, the Health System, and their employees and agents, including, but not limited to, the Athletic Trainers and the Team Physicians or Team Physician Assistants, from any and all liability in case of accident, injury, damage or other mishap in connection with all medical services or athletic trainer services they provide to the above-named student.

\_\_\_\_\_  
Parent/Guardian Signature\*

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date

**Authorization for Release of Medical Information**

I authorize the release of medical information to Frederica Academy by physicians and health care providers rendering services to Frederica Academy athletes. The purpose of the release of medical information is to allow Frederica Academy to determine the advisability of an athlete's participation in Frederica Academy athletics. An example would be the release of a screening physical examination. By agreeing to this release of medical information for my son, daughter or other person for whom I have the legal authority to act, I hereby authorize health care providers (including, but not limited to, the Health System and its physicians and athletic trainers) that are contracted with Frederica Academy to release to each other and to Frederica Academy oral and written information relating to the athlete's medical or physical condition, illness or injury that may have a bearing upon past, present, or future participation in athletics of Frederica Academy. The medical information will be used by Frederica Academy for the purposes of determining the advisability of the athlete's participation in Frederica Academy athletics. **This authorization is expressly bound by the following conditions:**

- I understand that my protected health information is protected by federal law under Health Information Portability and Accountability Act (HIPAA) may not be disclosed without my authorization under HIPAA.
- I understand that my signing of this authorization/consent is voluntary and I am not required to sign this authorization/consent in order to be eligible for participation in Frederica Academy athletics.
- I understand that seeking treatment at practice, in training room or evaluation/treatment during games may be in the view of the general public. Frederica Academy and the Health System are in compliance with HIPAA regulations, maintain all medical documents and records in confidentiality, but the nature of treatment in these areas allows for other patients, students, athletes, and staff to be in use of these facilities during my treatment. By signing this document, I understand the possible implications and consent to treatment.
- This authorization will automatically expire upon the athlete's termination of participation in or ineligibility to participate in Frederica Academy athletics, except to the extent relied upon for disclosures made prior to the automatic expiration. I have the right to revoke this authorization in writing at any time by sending written notification to the director of athletics at my institution. I understand that a revocation takes effect on its request date and does not affect any action taken prior to that date.
- I understand that there is a potential for information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.
- This authorization shall cover actions by and for Southeast Georgia Health System, Cooperative Healthcare Services, Inc. and all of their respective employees, workforce and business associates and all other physicians and healthcare providers contracted with Frederica Academy and their respective employees, workforce and business associates.

\_\_\_\_\_  
Parent/Guardian Signature\*

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date

\* This authorization must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the student's behalf. **By signing this form, you as the parent, guardian or a party acting in loco parentis warrant that you have the legal authority to act on the Athlete's behalf.** The signature may be only the athlete if the athlete is over 18 years of age.

**APPENDIX A**  
**CONCUSSION INFORMATION FOR STUDENT ATHLETES**

**NAME OF SCHOOL:** \_\_\_\_\_

According to the article “Concussion” by the Mayo Clinic Staff,<sup>1</sup> a concussion is defined and has symptoms as follows:

**Definition:**

A concussion is a traumatic brain injury that alters the way your brain functions. Effects are usually temporary, but can include problems with headache, concentration, memory, judgment balance and coordination.

Although concussions usually are caused by a blow to the head, they can also occur when the head and upper body are violently shaken. These injuries can cause a loss of consciousness, but most concussions do not. Because of this, some people have concussions and don’t realize it.

Concussions are common, particularly if you play a contact sport, such as football. But every concussion injures your brain to some extent. This injury needs time and rest to heal properly. Luckily, most concussive traumatic brain injuries are mild, and people usually recover fully.

**Symptoms:**

The signs and symptoms of a concussion can be subtle and may not be immediately apparent. Symptoms can last for days, weeks or even longer.

The most common symptoms after a concussive traumatic brain injury are headache, amnesia and confusion. The amnesia, which may or may not be preceded by a loss of consciousness, almost always involves the loss of memory of the impact that caused the concussion.

Signs and symptoms may include:

- \* Headache or a feeling of pressure in the head
- \* Temporary loss of consciousness
- \* Confusion or feeling as if in a fog
- \* Amnesia surrounding the traumatic event
- \* Dizziness or “seeing stars”
- \* Ringing in the ears
- \* Nausea or vomiting
- \* Slurred speech
- \* Fatigue

The well-being of its Student Athletes is of paramount importance to the School. Coaches are trained annually in recognizing the signs and symptoms of concussions and are required immediately to remove from practice, conditioning, or a game any Student Athlete who shows such signs. Student Athletes will not be permitted to return until a Health Care Provider has either ruled out a concussion or determines the Student Athlete capable of returning. In no instance will a Student Athlete with a diagnosed concussion return the same day.

PRINTED Student Name: \_\_\_\_\_

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_

PRINTED Parent Name: \_\_\_\_\_

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_

<sup>1</sup> <http://www.mayoclinic.com/health/concussion/DS00320>.

# Frederica Academy

## Student/Parent Sudden Cardiac Arrest Awareness Form

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 \_\_\_\_\_ 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 2022-2023 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: 5/19)

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Sex assigned at birth (F, M, or intersex): \_\_\_\_\_ How do you identify your gender? (F, M, or other): \_\_\_\_\_

List past and current medical conditions. \_\_\_\_\_

Have you ever had surgery? If yes, list all past surgical procedures. \_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). \_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). \_\_\_\_\_

#### Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (check box next to appropriate number)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

(A sum of  $\geq 3$  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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has a provider ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any ongoing medical issues or recent illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has a doctor ever told you that you have any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)		Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



## ■ PREPARTICIPATION PHYSICAL EVALUATION

### PHYSICAL EXAMINATION FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

#### PHYSICIAN REMINDERS

- Consider additional questions on more-sensitive issues.
  - Do you feel stressed out or under a lot of pressure?
  - Do you ever feel sad, hopeless, depressed, or anxious?
  - Do you feel safe at your home or residence?
  - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
  - During the past 30 days, did you use chewing tobacco, snuff, or dip?
  - Do you drink alcohol or use any other drugs?
  - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ ( _____ / _____ )	Pulse: _____	Vision: R 20/ _____ L 20/ _____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul>	<input type="checkbox"/>	
Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	
Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Skin <ul style="list-style-type: none"> <li>Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis</li> </ul>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck	<input type="checkbox"/>	
Back	<input type="checkbox"/>	
Shoulder and arm	<input type="checkbox"/>	
Elbow and forearm	<input type="checkbox"/>	
Wrist, hand, and fingers	<input type="checkbox"/>	
Hip and thigh	<input type="checkbox"/>	
Knee	<input type="checkbox"/>	
Leg and ankle	<input type="checkbox"/>	
Foot and toes	<input type="checkbox"/>	
Functional <ul style="list-style-type: none"> <li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>	<input type="checkbox"/>	

<sup>a</sup> 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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_