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St. Joseph's | Candler
www.sjchs.org

Sports Medicine

Dear Parent/Guardian:

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 information will provide important information about him/her. Please complete and sign as indicated and return to your child's coach.

THIS INFORMATION MUST BE COMPLETED BEFORE YOUR CHILD CAN PARTICIPATE IN ANY SPORT!

Athlete Name: ______________________ D.O.B. ____/____/____ Age: ______

Athlete Address: ____
Street City State Zip

Parent/Guardian Name: ______________________________________

Parent/Guardian Address: ____________________________________

Home Phone # (____) ______________ Work Phone # (____) ______________

Insurance Information:

Primary:
Company Name: ______________________

Policy Number: ______________________

Phone Number: ______________________

Secondary:
Company Name: ______________________

Policy Number: ______________________

Phone Number: ______________________

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PARENTAL CONSENT

The undersigned grants St. Joseph's/Candler Sports Medicine Center and its employees parental consent for your child's pre-participation medical screening and assessment and treatment of any sports injuries he/she may suffer during the __________ school year.

MEDICAL RELEASE

I give permission for the school official, chaperon, or representative of St. Joseph's/Candler Sports Medicine Center, involved in the activity with my child to seek medical aid or render first aid if such attention is necessary in the sole discretion of the said person involved. In case of emergency, and when I cannot immediately be reached by telephone or otherwise, I give permission to the physician selected by the school officials to hospitalize, secure proper treatment, order injections, anesthesia, or surgery for my child.

ACKNOWLEDGEMENT OF RISK

Both the student and the parent/guardian should read this statement carefully. You should be aware that playing or practicing or helping to play with or participating in any manner in any sport can be a dangerous activity involving risks of injury. The dangers and risks playing, practicing to play, helping or participating in sports include, but are not limited to: death, serious neck, head and/or spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, tendons, and other aspects of the body, general health and well being. Because of the dangers of participating in sports, the student should recognize the importance of following coaches' instructions regarding playing techniques, training, and other team rules and obey such instruction.

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

____

Parent/Guardian Signature Date

____

Athlete Signature Date

ST. Joseph's / Candler

Consent for a Pre-Participation Evaluation (PPE)

I, ______________________________, being of lawful age and residing at ____________________
______________________________, hereby authorize and consent to having St. Joseph's/Candler Health System, Inc. Athletic Trainers and/or their consulting physician(s) perform a Pre-Participation Evaluation (PPE) on me for the _________ school year I understand that this PPE is a health screening and is not intended to take the place of the physical exam that can be performed by a physician. I understand that the scope of this PPE (medical history, blood pressure/pulse screen, and heart/lung auscultation) WILL NOT IDENTIFY many of the medical problems known to be associated with sudden death in athletes. Some of those medical problems include but are not necessarily limited to cardiac abnormalities, pulmonary abnormalities, aneurysms, and/or sickle cell trait.

I hereby fully and forever release and discharge ST. JOSEPH'S/CANDLER HEALTH SYSTEM, INC., its subsidiaries and affiliated corporations, and their respective directors, trustees, officers, employees and agents and my physician(s) or any other person participating in my care from any and all claims, demands, damages, rights of action or causes of action, present or future, whether the same be known or unknown, anticipated or unanticipated, resulting from or arising out of the completion of this PPE.

I understand that this PPE is being carried out with my consent and so assume full responsibility for the limitations of this PPE in detecting many of the health problems associated with sudden death in athletes

______________________________ ______________________________
Signature of Patient **Date**

______________________________ ______________________________
Witness **Date**

When patient is an unemancipated minor, or is otherwise incompetent to give consent:

______________________________ ______________________________
Person Authorized to Consent for Patient (Parent or Guardian) **Date**

______________________________ ______________________________
Relationship to Patient **Witness**

Candler Hospital 5353 Reynolds Street Savannah, Georgia 31405 (912) 692-6000

ST. Joseph's/Candler

Authorization to Release Medical Information

I, ______________________________, being of lawful age and residing at ______________ ______________________________, hereby authorize and consent to having St. Joseph's/Candler Health System, Inc. Athletic Trainers and/or their consulting physician(s) provide any requested medical information to other physicians, other healthcare providers, my high school coaches or school administration, intercollegiate teams, professional teams, their scouts, recruiters, or athletic trainers which directly pertains to my athletic participation at ______________________________. Said authorization to release medical information will include, but is not necessarily limited to information concerning illnesses, injuries, treatments, hospitalizations, examinations, X-rays, or other forms of diagnostic testing occurring while participating in competitive athletics at said school or athletic organization.

I understand that I may revoke this authorization by providing written notice to St. Joseph's/Candler Health System, Inc. I also understand that I am waiving my right to privacy with regard to the medical records and patient identifiable information by authorizing the release of my information.

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.

______________________________ ______________________
Signature of Patient **Date**

______________________________ ______________________
Witness **Date**

When patient is an unemancipated minor, or is otherwise incompetent to give consent:

______________________________ ______________________
Person Authorized to Consent for Patient (Parent or Guardian) **Date**

______________________________ ______________________
Relationship to Patient **Witness**

Candler Hospital 5353 Reynolds Street Savannah Georgia 31405 (912) 692-6000

Effingham County Athletic Participation
Parental Consent and Insurance Information Form

WARNING: Although participation in supervised inter-scholastic athletics and activities may be one of the least hazardous in which students will engage in or out of school, **BY ITS NATURE, PARTICIPATION IN INTER-SCHOLASTIC 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 my child, ______________________________ to:

(1) compete in athletics at Effingham County High School of the Effingham County school District in Georgia High School Association approved sports CIRCLED below:

Baseball   Basketball   Cheerleading   Cross Country   Golf   Gymnastics   Football   Rifle Team

Soccer   Softball   Tennis   Track & Field   Volleyball   Wrestling   Weight Training

(2) Accompany any school team of which he/she is a member on any of its local or out-of-town trips.
(3) I hereby verify that the information on this form is correct and understand that any false information may result in my son/daughter being declared ineligible:
(4) **And, I consent to Internet storage and delivery of this information to medical providers as appropriate by DCATS.com, LLC.**

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

Insurance Information (please check one)

_____ My son/daughter is adequately and currently covered by accident insurance that will cover injuries sustained while participating in any school authorized activities (including, but not limited to Varsity or Junior Varsity Football).

____________________   ____________________   ____________________
Company Providing Insurance   Name of Insured   Policy/Group Number

_____ I have purchased the Benefit Plan provided by the Effingham County School System. I understand this is a supplemental policy. My signed copy of this Benefit Plan is on file at Effingham County High School.

______________________________   ____________________
Signature of the Student   **Date**

______________________________   ____________________
Person Authorized to Consent for Student   **Date**
(Parent of Guardian)

______________________________   ____________________
Relationship to the Student   **Witness**

Revised 7/1/05
Mandatory

Preparticipation Physical Evaluation

HISTORY FORM

Date of Exam ____________________

Name ______________________________ Sex________ Age________ Date of birth______________

Grade_____ School____________________ Sport(s)______________________________

Address ____ Phone______________

Personal Physician ____

In case of emergency, contact:

Name ____________________ Relationship____________ Phone (H)____________ Phone(W)____________

Explain "Yes" answers below.
Circle questions you don't know the answers to.

	Question	Yes	No
1	Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2	Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5	Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6	Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8	Does your heart race or skip beats during exercise?	☐	☐
9.	Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10	Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	☐	☐
11.	Has anyone in your family died for no apparent reason?	☐	☐
12	Does anyone in your family have a heart problem?	☐	☐
13	Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14	Does anyone in your family have Marfan syndrome?	☐	☐
15.	Have you ever spent the night in a hospital?	☐	☐
16.	Have you ever had surgery?	☐	☐
17.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
18	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19.	Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below	☐	☐

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes

	Question	Yes	No
20.	Have you ever had a stress fracture?	☐	☐
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22	Do you regularly use a brace or assistive device?	☐	☐
23.	Has a doctor ever told you that you have asthma or allergies?	☐	☐
24	Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25.	Is there anyone in your family who has asthma?	☐	☐
26.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
27	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28	Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30	Have you had a herpes skin infection?	☐	☐
31.	Have you ever had a head injury or concussion?	☐	☐
32.	Have you been hit in the head and been confused or lost your memory?	☐	☐
33	Have you ever had a seizure?	☐	☐
34.	Do you have headaches with exercise?	☐	☐
35	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37	When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39	Have you had any problems with your eyes or vision?	☐	☐
40.	Do you wear glasses or contact lenses?	☐	☐
41.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42.	Are you happy with your weight?	☐	☐
43	Are you trying to gain or lose weight?	☐	☐
44.	Has anyone recommended you change your weight or eating habits?	☐	☐
45	Do you limit or carefully control what you eat?	☐	☐
46	Do you have any concerns that you would like to discuss with a doctor?	☐	☐

FEMALES ONLY

	Question	Yes	No
47.	Have you ever had a menstrual period?	☐	☐

48. How old were you when you had your first menstrual period? ______
49. 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__________

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Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name ____ Date of Birth ______________

Height________ Weight________ % Body Fat (optional)________ Pulse_______ BP____ / ____ (____ / ____, ____ / ____)

Vision R 20/______ L 20/______ Corrected: Y N Pupils: Equal ______ Unequal______

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only
+Having a third party present is recommended for the genitourinary examination

Notes: ____

____

Name of physician (print/type)____ Date______________

Address____ Phone______________

Signature of physician ____, MD or DO

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Preparticipation Physical Evaluation

CLEARANCE FORM

Name______________________________ Sex__________ Age________ Date of birth______________

☐ Cleared without restriction

☐ Cleared, with recommendations for further evaluation or treatment for: ______________________

____

____

____

☐ Not Cleared for ☐ All sports ☐ Certain sports: ______________ Reason: ______________

Recommendations: ____

____

EMERGENCY INFORMATION

Allergies ____

Other Information ____

Name of physician (print/type) ______________________________ Date ______________

Address ______________________________ Phone ______________

Signature of physician ______________________________, MD or DO

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Preparticipation Physical Evaluation

CLEARANCE FORM

Name______________________________ Sex__________ Age________ Date of birth______________

☐ Cleared without restriction

☐ Cleared, with recommendations for further evaluation or treatment for: ______________________

____

____

____

☐ Not Cleared for ☐ All sports ☐ Certain sports: ______________ Reason: ______________

Recommendations: ____

____

EMERGENCY INFORMATION

Allergies ____

Other Information ____

Name of physician (print/type) ______________________________ Date ______________

Address ______________________________ Phone ______________

Signature of physician ______________________________, MD or DO

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Dear Parent/Guardian:

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 information will provide important information about him/her. Please complete and sign as indicated.

School: ____________________

Athlete's Name: ____________________ DOB: __________

Athlete's Address: ____________________

Parent/Guardian Name: ____________________

Parent/Guardian Address. ____________________

Home Phone: __________ Work Phone: __________

Primary:
Insurance Company Name: __________ Policy Number: __________

HMO ☐ Preferred Hospital: __________

PPO ☐ Primary Care Physician: __________

Secondary:
Insurance Company Name: __________ Policy Number: __________

HMO ☐ Preferred Hospital: __________

PPO ☐ Primary Care Physician: __________

Medical Consent to Treat

The undersigned grants the representative from St. Joseph's/Candler Health System Sports Medicine Center and its employees parental consent for treatment of your child's sports injuries that may he/she may suffer during the school year.

I give permission for the school official, chaperone, or representative of the St. Joseph's/Candler Health System Sports Medicine Center, involved in the activity with my child, to seek medical aid, render first aid if such attention is necessary in the sole discretion of said person involved. In case of emergency and when I cannot be immediately reached by telephone or otherwise, I give permission to the physician selected by the school officials to hospitalize, secure proper treatment, and order injections, anesthesia, or surgery for my child.

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

PARENT/GUARDIAN ____________________ DATE __________

STUDENT ____________________ DATE __________