

Brantley County Athletics Information

Name of Athlete: _____ Grade: 6 7 8 9 10 11 12
Parents Name: _____ Phone: _____
Mailing Address: _____ Choose One:
City, State, Zip: _____ Birthdate: _____

Insurance Verification

All students who participate in Brantley County Athletics must provide proof that they are covered under an insurance plan. If your child is not currently covered under a family policy, insurance may be purchased through the school. Please provide the following information concerning your child's insurance.

Insurance Company: _____

Address: _____

Phone #: _____

Policy #: _____ Group #: _____

I verify that my child is covered under the insurance policy named above.

My child will need to purchase insurance through the school. Please send an insurance application form.

Signature of Parent/Guardian

Date of Signature

Athletic Consent

I give my consent for _____ to participate in organized middle/high school athletics, realizing that such activity involves the potential for injury which is inherent in all sports. I acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observance of rules, injuries are still a possibility, paralysis or even death. I acknowledge that I have read and understand this warning.

This consent includes travel to and from athletic contests and practice sessions. I further consent to treatment deemed necessary by physicians designated by school authorities for any illness or injury resulting from his/her athletic participation.

Signature of Parent/Guardian

Date of Signature

Consent to Treatment and Waiver of Liability Form

I _____ am the parent or legal guardian of _____ . I understand that Southeast Georgia Health System provides athletic training, first aid and certain other medical services in connection with certain athletic events and programs of Brantley County High School, a part of the Brantley County School System ("Brantley County High School"). 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 Southeast Georgia Health System present requires immediate medical or surgical attention, I hereby grant permission to such school authorities and Southeast Georgia 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 hereby release and agree to hold harmless Brantley County High School, Southeast Georgia 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 Brantley County High School by physicians and health care providers ("providers") rendering services to Brantley County High School athletes. The purpose of the release of medical information is to allow Brantley County High School to determine the advisability of an athlete's participation in Brantley County High School 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, Southeast Georgia Health System and its physicians and athletic trainers) that are contracted with Brantley County High School to release to each other and to Brantley County High School 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 Brantley County High School. The medical information will be used by Brantley County High School for the purposes of determining the advisability of the athlete's participation in Brantley County High School athletics.

This authorization is expressly bound by the following conditions:

- This authorization will automatically expire upon the athlete's termination of participation in or ineligibility to participate in Brantley County High School athletics, except to the extent relied upon for disclosures made prior to the automatic expiration.
- This authorization may be revoked at any time, provided the revocation is a properly executed written document and delivered to the appropriate Athletic Director. As soon as practicable, Brantley County High School shall inform each contracted health care provider of each athlete's revocation. However, any such revocation shall not affect disclosures made by a health care provider prior to that health care provider's receipt of the revocation from Brantley County High School. In addition, such revocation shall not affect disclosures made prior to the receipt of the revocation to the extent that this authorization was relied upon for such disclosures.
- This authorization is not intended to alter the athlete's ability to receive medical care from any health care provider regardless of whether or not this authorization is agreed to or refused.
- 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 Brantley County High School 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.

Georgia High School Association

Student/Parent Sudden Cardiac Arrest Awareness Form

SCHOOL: Brantley County High 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 Brantley County 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 2026-2027 school year. This form will be stored with the athletic physical form and other accompanying forms required by the Brantley 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

Georgia High School Association Student/Parent Concussion Awareness Form

SCHOOL: Brantley County High School

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 Brantley County High School 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 2026-2027 school year. This form will be stored with the athletic physical form and other accompanying forms required by the Brantley 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: 3/25)

■ 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: _____
(First Name) (Last Name)

Date of examination: _____ Sport(s): _____

Sex assigned at birth: _____

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.)

(First Name)

(Last Name)

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 <i>Staphylococcus aureus</i> (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?		

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: _____

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2023 This form has been modified for use by the GHSA

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ (First Name) _____ (Last 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"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) 		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> Pupils equal Hearing 		
Lymph nodes		
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (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 <ul style="list-style-type: none"> 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: _____
