■ 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.

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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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■ 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

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■ 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: ______________________________

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Georgia High School Association
Student/Parent Concussion Awareness Form

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 ______________________________ 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 2020-2021 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: 2/20)

Georgia High School Association
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 <u>cannot</u> 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 Schoo 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 2020-2021 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: 2/20)

The Hughston Foundation, Inc. & The Hughston Clinic, P.C.
Authorization to Release Medical Information

I, ______________________________, being the parent/legal guardian of ______________________________ and residing at ______________________________ ______________________________, do hereby authorize and consent to having The Hughston Foundation, Inc.'s and/or The Hughston Clinic, P.C.'s athletic trainers and/or consulting physician(s) provide any requested medical information to other physicians, other healthcare providers, the high school coaches or school administration, intercollegiate teams, professional teams, their scouts, recruiters, or athletic trainers which directly pertains to such child's or ward's (collectively "child") 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, or otherwise medically related to such child.

I understand that I may revoke this Authorization by providing written notice to The Hughston Foundation, Inc., a Georgia nonprofit corporation. I also understand that if information has been released by relying upon this Authorization, that revocation will not be valid. I understand that injury treatment will not be conditioned upon signing this Authorization. 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.

I understand that the release of the medical information provided for herein is being carried out with my consent as the parent or legal guardian of such child, and accordingly, I assume full responsibility for any action taken in reliance upon this Authorization.

I UNDERSTAND THAT SUCH CHILD'S MEDICAL INFORMATION IS CONFIDENTIAL AND PROTECTED BY A PHYSICIAN-PATIENT PRIVILEGE AND THAT I, AS THE PARENT OR LEGAL GUARDIAN OF SUCH CHILD, AM WAIVING THE PHYSICIAN-PATIENT PRIVILEGE TO THE FULL EXTENT PROVIDED FOR HEREIN AND AS ALLOWED BY LAW.

______________________________ ______________________________
Signature of Parent/Legal Guardian **Date**

____
Print Name of Parent/Legal Guardian

______________________________ ______________________________
Signature of Student Athlete **Date**

____
Print Name of Student Athlete

THE HUGHSTON FOUNDATION, INC. & THE HUGHSTON CLINIC, P.C.

CONSENT TO TREATMENT

Dear Parent/Guardian:

In order to provide the best possible medical care for your child or ward (hereinafter, collectively, "child"), a medical record will be established for him/her. If your child should become injured while playing sports, this record will provide important information about him/her. Please complete and sign as indicated and return to your child's coach. Your signature serves as permission to treat your child until 18 years of age or until he/she has completed activity participation.

THIS INFORMATION MUST BE COMPLETED BEFORE YOUR CHILD CAN BE EVALUATED / TREATED FOR ANY INJURY THAT MAY OCCUR

Athlete Name: ______________________ D.O.B. ___/___/___

Athlete Address: ______________________
Street City State Zip

Parent/Guardian Name: ______________________

Parent/Guardian Address: ______________________
Street City State Zip

Home Phone: ______________ Work Phone: ______________

Guaranteed contact number - Pager, Cell Phone, etc. ______________

INSURANCE INFORMATION

Primary:

Company Name: ______________

Policy and/or Group No.: ______________

Secondary:

Company Name: ______________

Policy and/or Group No.: ______________

ALLERGIES/MEDICAL CONDITIONS

My child's doctor is: ______________________

My child is currently taking the following medications: ______________________

____

My child has the following allergies or medical conditions: ______________________

____

PARENTAL CONSENT

The undersigned grants consent to The Hughston Foundation, Inc. and to The Hughston Clinic, P.C., and to their respective employees, for the child listed above to receive an assessment and the treatment of any injuries he/she may suffer during the school year. Injury treatment would include the application of modalities such as cold, heat, electrical muscle stimulation and/or ultrasound if necessary, as well as therapeutic exercises, to safely speed recovery and return to activity.

MEDICAL RELEASE

I, the undersigned, give permission for school officials, chaperons, or representatives of The Hughston Foundation, Inc. and The Hughston Clinic, P.C. involved in the activity with my child to seek medical attention or render first aid if such attention is necessary in the discretion of the said person involved. In case of emergency, and when I cannot immediately be contacted, 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, practicing, conditioning and preparing for participation in any sport can be a dangerous activity involving risks of injury. The dangers and risks of sports participation 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 teams' rules and obey such instruction.

ASSUMPTION OF RESPONSIBILITY

It is my desire that my child participate in such athletic activities for which the within Consent to Treatment, Medical Release and Acknowledgement of Risk is being given by me as the parent or legal guardian of such child and as a precondition to my child's participation in such athletic activities. I fully understand the importance, consequences and affects of the within Consent to Treatment, Medical Release and Acknowledgement of Risk that I am entering into on behalf of myself and on behalf of my child, I have fully disclosed any medications, allergies or medical conditions that my child may have, and I assume full responsibility for any action taken in reliance upon the provisions hereof.

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

SIGNATURE OF PARENT/GUARDIAN DATE

Print Parent's/Guardian's Name

STUDENT ATHLETE DATE

Print Student Athlete's Name

MUSCOGEE COUNTY ATHLETICS

Assumption of Risk & Waiver of Liability

Student – Athlete Name: (Please Print)		Home Street Address:		
Date of Birth:	Student Cell Phone: ( ) -	City:	State:	Zip:
Grade (for 2020-2021):	School (for 2020-2021):	In what extra-curricular activities will the student-athlete participate in?		

Parent/Guardian Name:	Parent Cell #: ( ) -	Email Address:
2nd Parent/Guardian Name:	Parent Cell #: ( ) -	Email Address:

EMERGENCY CONTACT – Other than Parents listed above:

Name: Relationship: Phone#: ( ) -

INSURANCE INFORMATION

The MCSD requires that all students who participate in athletics be adequately covered by health insurance (proof of health insurance). ***Changes/updates to student insurance coverage must be communicated by a parent/guardian to the Site-School Athletic Director.***

Name of Insurance Company:	**Policy No:**
Address: /	**Group No:**

Student Eligibility to Participate- We have read and discussed the general requirements for athletic eligibility. We understand that any questions we have should be directed to our student's coach, site-school athletic director, or the building Principal.

Supervision and Rules - We understand that the student will be under the supervision and direction of a MCSD athletic coach or other MCSD personnel. We agree to follow the rules of the sport and the instructions of the coach. I acknowledge and agree that enroute to and from, and during this sport activity, the student will be subject to all MCSD disciplinary rules and the MCSD Student Code of Conduct.

Authorization to Treat and Provision of Information - I acknowledge and agree that I am responsible for informing appropriate District personnel of any medical, allergy, behavioral, or other needs of the student and authorize MCSD personnel to take any and all actions, medical or otherwise, they believe necessary while the student is under their supervision.

We certify that all of the information provided by us on this form is accurate. We grant MCSD permission and authority to obtain necessary medical care and/or treatment for the student. Treatment may include, but is not limited to first aid, CPR, transport by ambulance, and / or medical or surgical treatment recommended by a physician. We accept the financial responsibility for any such medical care or treatment.

Transportation – We request that the student named in this form be transported by the MCSD and authorize such transportation in to practices, competitions, and similar. We freely, knowingly, and willfully accept and assume the risk of injury and even death that is associated with transportation. We understand that transportation may or may not be available through the MCSD. If an MCSD-approved bus or an MCSD-approved charter bus is not available, we understand that transportation will be the parent/guardian's responsibility, and we will arrange for transportation.

COVID-19 Acknowledgment: We acknowledge that the above named student-athlete is attending these workouts voluntarily. If the student-athlete shows any signs of COVID-19 illness, such as a cough, sore throat or a temperature above 100.0, we will keep the student at home and contact the head coach. We understand that if the student-athlete is at workouts and begins to show any signs of COVID-19, we will be contacted immediately and expected to pick up immediately. A student-athlete who becomes sick must either be quarantined for 14 days with no symptoms or provide the head coach with a negative COVID-19 test. If one of the athletes in my child's group tests positive for COVID-19, the entire group will be quarantined for 14 days. Students will receive a temperature check and be asked a series of questions about COVID-19 risks before each workout.

Waiver of Liability Relating to Coronavirus/COVID-19: The novel coronavirus, COVID-19, has been declared a worldwide pandemic. COVID-19 is extremely contagious. Every individual faces risks of infection from the virus, whether at work, at home or engaged in activities away from work. This guidance is an effort to share information. The below considerations should be followed as is reasonable under the given circumstances and re-evaluated as new orders and advisories are introduced through public health officials, and governmental agencies. The virus is believed to spread from person-to-person contact and/or by contact with

contaminated surfaces and objects, and through the air. People can be infected and show no symptoms but still spread the disease. There is no known treatment, cure, or vaccine for COVID-19. Evidence has shown that COVID-19 can cause serious and potentially life threatening illness and even death.

Even though steps are being implemented to reduce the risk of transmission, MCSD cannot prevent your child from being exposed to, contracting, or spreading COVID-19 if you decide your child will participate in school athletic activities. It is not possible to eliminate the risk of contracting the disease. Therefore, if you choose for your child to participate you may be exposing your child, your family and others to a risk of contracting or spreading COVID-19.

ASSUMPTION OF RISK: I have read and understand the above warning concerning COVID-19. I hereby choose to accept the risk that my child may contract COVID-19 while engaging in school athletic activities. I further accept the risk that, if my child contracts COVID-19, that he or she may spread the virus to others he or she comes in contact with, including family members. I accept these risks because I want my child to participate in school athletics.

WAIVER OF LAWSUIT/LIABILITY: I hereby forever release and waive on behalf of myself, my heirs, executors or assigns any right to bring suit for myself or on behalf of my child against MCSD and its officers, administrators, teachers, officials, agents, employees, or other representatives in connection with exposure, infection, and/or spread of COVID-19 related to participating in school athletic activities. I understand that this waiver means I give up my right to bring any claims including for personal injuries, death, disease or any other loss I may have to seek damages, whether known or unknown, foreseen or unforeseen.

CHOICE OF LAW: I understand and agree that the law of the State of Georgia will apply to this contract.

I HAVE CAREFULLY READ AND FULLY UNDERSTAND ALL PROVISIONS OF THIS RELEASE, AND FREELY AND KNOWINGLY ASSUME THE RISK ON BEHALF OF MYSELF AND MY CHILD AND WAIVE MY RIGHTS CONCERNING LIABILITY AS DESCRIBED ABOVE.

General Risk of Injury: We acknowledge and understand that there is a risk of injury involved in athletic participation. We understand that the student-athlete will be under the supervision and direction of a MCSD athletic coach. We agree to follow the rules of the sport and the instructions of the coach in order to reduce the risk of injury to the student and other athletes. However, we acknowledge and understand that neither the coach nor MCSD can eliminate the risk of injury in sports. Injuries may and do occur. Sports injuries can be severe and in some cases may result in permanent disability or even death. We freely, knowingly, and willfully accept and assume the risk of injury that might occur from participation in athletics.

Hold Harmless Agreement: As a lawful parent/guardian of the above-named student, I hereby give permission for my child to participate in school sponsored extra-curricular activities. By signing this form, I agree that I have fully read, understand and agree to the conditions set forth below:

I acknowledge and agree that, during this school sponsored activity, my child will be subject to any and all Muscogee County School District (MCSD) disciplinary rules and Student Code of Conduct to which he or she is subject during the school day. I further understand that, during this activity, my child will be subject to the supervision and direction of those adults who accompany the students on behalf of MCSD. I consent for/to my child's participation in extra-curricular activities. I acknowledge and agree that I am responsible for informing appropriate District personnel of any medical needs of my child and authorize MCSD personnel, or other chaperones, to take any and all medical actions they believe necessary for my child until such time as I may be contacted. I acknowledge and agree that MCSD, its officers, employees, agents and volunteers do not have or assume any liability for damages, losses, or injuries to the above-named student as a result of the student participating in this activity. I acknowledge and agree, there is not school district insurance to cover any injuries, losses, or damages during a school activity. I acknowledge and agree that any revocation of permission given by this form can only be in writing and must be delivered to the appropriate school officials to be effective.

CERTIFICATION AND MEDICAL AUTHORIZATION: We certify that all of the information provided on this form is correct. We agree to abide by state and local rules. If the student-athlete is injured while participating in athletics and MCSD is unable to contact the parent, we grant MCSD permission and authority to obtain necessary medical care and/or treatment for the student's injury. Treatment may include, but is not limited to first aid, CPR, medical or surgical treatment recommended by a physician. We accept the financial responsibility for such medical care or treatment.

We, the undersigned student and parent/guardian, have read this document and understand all of the expectations for athletic participation at my school.

Student:	Date:
Parent/Guardian:	Date: