

## ■ 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): \_\_\_\_\_

Gender (Male or Female): \_\_\_\_\_

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"/>
2. Has a provider ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any ongoing medical issues or recent illness?	<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"/>
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<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"/>
7. Has a doctor ever told you that you have any heart problems?	<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"/>

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"/>
10. Have you ever had a seizure?	<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"/>
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"/>
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>	
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>	
MEDICAL QUESTIONS		Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>	
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	<input type="checkbox"/>	<input type="checkbox"/>	
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?	<input type="checkbox"/>	<input type="checkbox"/>	
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
22. Have you ever become ill while exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	
23. Do you or does someone in your family have sickle cell trait or disease?	<input type="checkbox"/>	<input type="checkbox"/>	
24. Have you ever had or do you have any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	

MEDICAL QUESTIONS (CONTINUED)		Yes	No
25. Do you worry about your weight?	<input type="checkbox"/>	<input type="checkbox"/>	
26. Are you trying to or has anyone recommended that you gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>	
27. Are you on a special diet or do you avoid certain types of foods or food groups?	<input type="checkbox"/>	<input type="checkbox"/>	
28. Have you ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
FEMALES ONLY		Yes	No
29. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>	
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

- 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 • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)	<input type="checkbox"/>	
Eyes, ears, nose, and throat • Pupils equal • Hearing	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	
Heart <sup>a</sup> • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis	<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 • Double-leg squat test, single-leg squat test, and box drop or step drop test	<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: \_\_\_\_\_

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





**GEORGIA INDEPENDENT ATHLETIC ASSOCIATION  
STUDENT / PARENT CONCUSSION AWARENESS FORM**

**DANGERS OF CONCUSSION**

Concussions at all levels of sports have received a great deal of attention and a State Law has been passed to address this issue. Adolescent athletes are particularly vulnerable to the effects of concussion. Once considered little more than a minor "ding" to the head it is now understood that a concussion has the potential to result in death, or changes in brain function (either short-term or long term). A concussion is a brain injury that results in a temporary disruption of normal brain function. A concussion occurs when the brain is violently rocked back and forth or twisted inside the skull as a result of a blow to the head or body. Continued participation in any sport following a concussion can lead to worsening concussion symptoms, as well as increased risk for further injury to the brain, and even death.

Player and parental education in this area is crucial – that is the reason for this document. Refer to it regularly. This form must be signed by a parent or guardian of each student who wishes to participate in GIAA 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.)

**GIAA Concussion Policy:** If a Coach observes a Student-Athlete exhibit any sign, symptom, or behavior consistent with a concussion or head injury, the Coach must immediately remove that Student-Athlete from practice, conditioning, or game. The Student-Athlete may not return to practice, conditioning, or game until a Health Care Provider has determined that the Student-Athlete has not suffered a concussion. In the case where a Health Care Provider has determined that the Student-Athlete has suffered a concussion, the Student-Athlete may not resume practice, conditioning, or participation in games until medically determined capable of doing so for full or graduated return. In no circumstance may a Student-Athlete return to practice, conditioning, or a game on the same day that a concussion has been diagnosed by a Health Care Provider or cannot be ruled out

***By signing this Concussion Awareness Form, we give permission to the school to transfer this Form to all sports that this child may play. We are aware of the dangers of concussions and this signed Form will represent myself and this child during the current school year \_\_\_\_\_. This form will be stored with the Athlete's Physical Form and any other accompanying forms required by the Georgia Independent Athletic Association (GIAA).***

**WE HAVE READ THIS FORM AND UNDERSTAND THE FACTS REPRESENTED IN IT.**

SCHOOL NAME: First Presbyterian Day School

STUDENT'S NAME: \_\_\_\_\_ STUDENT'S SIGNATURE: \_\_\_\_\_  
(PRINTED)

PARENT'S NAME: \_\_\_\_\_ PARENT'S SIGNATURE: \_\_\_\_\_  
(PRINTED)

DATE SIGNED: \_\_\_\_\_



**GEORGIA INDEPENDENT ATHLETIC ASSOCIATION**  
**STUDENT / PARENT SUDDEN CARDIAC ARREST AWARENESS FORM**

**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.

**LEARN TO RECOGNIZE SUDDEN CARDIAC ARREST**

If you see someone collapse, assume they have 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). Call for help and start CPR. You cannot hurt them.

**LEARN HANDS-ON 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 is 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, we give permission to the school to transfer this Form to all sports that this child may play. We are aware of the dangers of sudden cardiac arrest and this signed Sudden Cardiac Arrest Form will represent myself and this child during the current school year \_\_\_\_\_. This form will be stored with the Athlete’s Physical Form and any other accompanying forms required by the Georgia Independent Athletic Association (GIAA).***

**WE HAVE READ THIS FORM AND UNDERSTAND THE FACTS REPRESENTED IN IT.**

SCHOOL NAME: First Presbyterian Day School

STUDENT’S NAME: \_\_\_\_\_ STUDENT’S SIGNATURE: \_\_\_\_\_  
(PRINTED)

PARENT’S NAME: \_\_\_\_\_ PARENT’S SIGNATURE: \_\_\_\_\_  
(PRINTED)

DATE SIGNED: \_\_\_\_\_



# GEORGIA INDEPENDENT ATHLETIC ASSOCIATION

## HEAT POLICY AWARENESS FORM

### Definitions:

- A. **"Practice"** means the period of time that a student engages in coach-supervised, school-approved preparation for sport whether indoors or outdoors, including Acclimation Activities, conditioning, weight training, distance running, and scrimmages, but not including a Walk Through.
- B. **"Walk Through"** means the period of time, not exceeding one hour per day, that a student engages in coach-supervised, school-approved sessions, whether indoors or outdoors, to work on formations, schemes, and techniques without physical contact. No protective equipment is worn during a Walk Through. No conditioning activities are held during a Walk Through. A Walk Through may not be held on a day when two practices are being held.
- C. **"Acclimation Activities"** in football means practicing in shorts, shoulder pads, and helmets for five consecutive weekdays prior to practicing in full pads. No contact will be allowed during this period. Starting Date for Acclimation is July 22.
- D. **"WBGT"** stands for the Wet Bulb Globe Temperature reading, which is a composite temperature used to estimate the effect of air temperature, humidity, and solar radiation on the human body, expressed in degrees. It is not equated with the "Heat Index."

**Policy:** All Member Schools will utilize at each Practice a scientifically approved instrument that measures WBGT. At the following WBGT readings the corresponding activity, hydration, and rest break guidelines apply:

### Under 82.0

**Normal activities.** Provide at least three separate rest breaks each hour of a minimum duration of 3 minutes each during Practice.

### 82.0 - 86.9

**Use discretion for intense or prolonged exercise.** Watch at-risk students carefully. Provide at least three separate rest breaks each hour of a minimum of four-minute duration each during Practice.

### 87.0 - 89.9

**Maximum outdoor Practice time is two hours.** For football, students are restricted to helmets, shoulder pads, and shorts during Practice. All protective equipment must be removed for conditioning activities. For all sports, provide at least four separate rest breaks each hour of a minimum of four minutes each during Practice.

### 90.0 - 92.0

**Maximum outdoor Practice time is one hour.** No protective equipment may be worn during outdoor Practice and there may be no outdoor conditioning activities. There must be twenty minutes of rest breaks provided during the hour of outdoor Practice.

### Over 92

**No outdoor activities or exercise.** Delay outdoor Practice until a lower WBGT reading occurs.

The following guidelines apply to **hydration and rest breaks**:

- Rest time should involve both unlimited hydrations (water or electrolyte drinks) and rest without any activity involved.
- For football, helmets should be removed during rest time.
- The site of the rest time should be a cooling zone not in direct sunlight, such as indoors, under a tent, or under a shade tree.
- When the WBGT is over 86, ice towels and spray bottles filled with ice water should be available in the cooling zone and cold immersion tubs will be available for a student showing signs of heat illness. A cold immersion tub may be anything, including a shower or wading pool that can be adapted to immerse a student in cold water and ice which is available within two-minutes travel from an outdoor Practice facility.

The following guidelines apply to **Practice**:

- All Member Schools must hold Acclimation Activities.
- No two-a-day Practices may exceed four hours for both sessions; no single Practice during two-a-days may exceed two hours. A three-hour rest period must be observed between the two sessions.
- No single Practice may last more than three hours.

Restrictions based on outdoor WBGT readings do not apply to indoor Practice where indoor air temperature is 85 degrees or less.

### Penalties

Member Schools violating this policy will be fined a minimum of \$500 and a maximum of \$1,000 for the first offense. A Member School may be removed from membership for repeat violations.

***By signing this Heat Policy Form, we give permission to the school to transfer this Form to all sports that this child may play. We are aware of the dangers of heat and this signed Form will represent myself and this child during the current school year 2024-2025. This form will be stored with the Athlete's Physical Form and any other accompanying forms required by the Georgia Independent Athletic Association (GIAA).***

SCHOOL: First Presbyterian Day School

ATHLETIC DIRECTOR'S SIGNATURE:  DATE: 3.25.2024

STUDENT ATHLETE'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PARENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



Directions to add an athlete account to ATS:

1. Go to the following link: **fpdmacon2.atsusers.com**

If the above link does not work please type in fpdmacon2.atsusers.com in any web browser.

2. Login in using: athlete id = **new** and the password = **new**
3. Select a team for your child. Up to 3. (FPD can change this later if needed. If you don't know use Coed FPD student only)
4. Input all available info including email (school email if possible), Cell #, text address, and additional address if parents do not live together.
5. Athlete ID should be first initial, last name, 2 digit graduation year. For Example, if John Doe Graduates in year XX, his ID should be JDoeXX
6. Select a password that the child can remember.
7. If your child has any medical alerts, allergies, or medication needed daily you would input that on this page.
8. Click save athlete information at the bottom of the page. When you have saved the athlete information new tabs will appear above.

#### **Medical History**

1. You can add information about recent surgeries or significant medical history

#### **Contacts**

1. Add emergency contacts here. Start with all parents. Then add at least two non-parent emergency contacts.

#### **Insurance**

1. This is not necessary. FPD does not bill for services rendered through the athletic training facility.

#### **Immunizations/paperwork and eFiles**

1. These tabs do not need to be filled.