

## PREPARTICIPATION EVALUATION

## EMERGENCY TREATMENT FORM

To All Parents/Guardians:

Many hospitals and doctors will not treat a child without parent's consent (unless a matter of life or death). It is requested that you complete the information below so that if your child requires a visit to the hospital while under the supervision of the school, this will allow the hospital to treat the injury.

### EMERGENCY INFORMATION

Name: \_\_\_\_\_ Sport(s): \_\_\_\_\_ 2011-2012 Grade: \_\_\_\_\_

Sex: M \_\_\_\_\_ F \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Home Address: \_\_\_\_\_ (City) \_\_\_\_\_ (Zip) \_\_\_\_\_

Home Phone #: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Secondary Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Medical Conditions: (Asthma, Diabetes, Seizures, etc.) \_\_\_\_\_

### I. Consent Statement: Authorizing Treatment

I hereby give my consent for (student's name) \_\_\_\_\_ to be treated in the event of an emergency, injury or illness.

Name of Parent/Guardian: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

### II. Consent Statement: Representing School

I hereby give my consent for (student- athlete's name) \_\_\_\_\_ to represent Gallatin High School in the sport(s) of \_\_\_\_\_.

Name of Parent/Guardian: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

PREPARTICIPATION EVALUATION

HISTORY FORM

NAME: \_\_\_\_\_ SPORT(S): \_\_\_\_\_

EXPLAIN "YES" ANSWERS BELOW. CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWERS TO.

- 1. Has a doctor ever denied or restricted your participation in sports for any reason? Y N
2. Do you have an ongoing medical condition (like diabetes or asthma)? Y N
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? Y N
4. Do you have allergies to medicines, pollens, foods, or stinging insects? Y N
5. Have you ever passed out or nearly passed out DURING exercise? Y N
6. Have you ever passed out or nearly passed out AFTER exercise? Y N
7. Have you ever had discomfort, pain, or pressure in your chest during exercise? Y N
8. Does your heart race or skip beats during exercise? Y N
9. Has a doctor ever told you that you have: High Blood Pressure Y N, High Cholesterol Y N, A heart murmur Y N, A heart infection Y N
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) Y N
11. Has anyone in your family died for no apparent reason? Y N
12. Does anyone in your family have a heart problem? Y N
13. Has any family member or relative died of heart problems or of sudden death before age 50? Y N
14. Does anyone in your family have Marfan Syndrome? Y N
15. Have you ever spent the night in a hospital? Y N
16. Have you ever had surgery? Y N
17. Have you every had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? Y N
18. Have you had any broken or fractured bones or dislocated joints? Y N
19. Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? Y N
20. Have you ever had a stress fracture? Y N
21. Have you been told that you have or have had an x-ray for atlantoaxial (neck) instability? Y N
22. Do you regularly use a brace or assistive device? Y N

- 23. Has a doctor ever told you that you have asthma or allergies? Y N
24. Do you cough, wheeze or have difficulty breathing during or after exercise? Y N
25. Is there anyone in your family who has asthma? Y N
26. Have you ever used an inhaler or taken asthma medicine? Y N
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? Y N
28. Have you had infectious mononucleosis (mono) within the last month? Y N
29. Do you have rashes, pressure sores, or other skin problems? Y N
30. Have you ever had a herpes skin infection? Y N
31. Have you ever had a head injury or concussion? Y N
32. Have you been hit in the head and been confused or lost your memory? Y N
33. Have you ever had a seizure? Y N
34. Do you have headaches with exercise? Y N
35. Have you ever had numbness, tingling or weakness in your arms or legs after being hit or falling? Y N
36. Have you ever been unable to move your arms or legs after being hit of falling? Y N
37. When exercising in the heat, do you have severe muscle cramps or become ill? Y N
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? Y N
39. Have you had any problems with your eyes or vision? Y N
40. Do you wear glasses or contact lenses? Y N
41. Do you wear protective eyewear, such as goggles or a face shield? Y N
42. Are you happy with your weight? Y N
43. Are you trying to gain or lose weight? Y N
44. Has anyone recommended you change your weight or eating habits? Y N
45. Do you limit or carefully control what you eat? Y N
46. Do you have any concerns that you would like to discuss with a doctor? Y N

FEMALES ONLY

- 47. Have you ever had a menstrual period? Y N
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.

Name of Parent/Guardian: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

Name of Student-Athlete: \_\_\_\_\_ Student-Athlete Signature: \_\_\_\_\_

**PREPARTICIPATION EVALUATION**

**PHYSICAL EXAMINATION FORM**

NAME: \_\_\_\_\_ SPORT(S): \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ PULSE: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_\_ )

VISION: R 20/\_\_\_\_ L 20/\_\_\_\_ CORRECTED: Y N If Yes, Glasses \_\_\_\_ Contacts \_\_\_\_ PUPILS: EQUAL \_\_\_\_ UNEQUAL \_\_\_\_

IMMUNIZATIONS: Up to date \_\_\_\_\_ Not up to date \_\_\_\_\_ Specify \_\_\_\_\_

SICKLE CELL TRAIT: Positive \_\_\_\_\_ Negative \_\_\_\_\_ Unknown \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)**			
Skin			
<b>MUSCULOSKELETAL</b>			
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.

\_\_\_\_\_ Cleared without restriction

\_\_\_\_\_ Not cleared for \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of physician (print/type): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of physician: \_\_\_\_\_, MD or DO

Questions taken from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, & American Osteopathic Academy of Sports Medicine 2004 PPE Form.

**PREPARTICIPATION EVALUATION**

**CONSENT FORM**

NAME: \_\_\_\_\_ SPORT(S): \_\_\_\_\_

**PROTECTED HEALTH INFORMATION AUTHORIZATION FOR RELEASE OF INFORMATION**

I/We hereby authorize any medical provider associated with Gallatin High School to use and/or disclose my child's clearance and health recommendations to the athletic director, coaches and medical personnel at Gallatin High School to inform them of their health status for the participation in athletic or activities. I/We understand my refusal to sign this authorization may affect my child's ability to participate in athletics. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by state or federal law.

Name of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

**LEGAL MEDICAL CONSENT**

I/We hereby give consent for (student-athlete's name) \_\_\_\_\_ to represent Gallatin High School in athletics realizing that such activity involves the potential for injury. I/We acknowledge that even the best coaching, use of the most advanced equipment, and strict observance of rules, injuries are still possible. On rare occasions these injuries are severe and result in total disability, paralysis, or even death. I/We further grant permission to Gallatin High School and TSSAA, its physicians, athletic trainers, and/or EMT to render aid, treatment, medical or surgical care deemed reasonably necessary to the health and well being of the student-athlete named above during or resulting from participation in athletics. By the execution of this consent, the student athlete named above and his/her parent/guardian(s) do hereby consent to screening, examination, and testing of the student athlete during the course of the pre-participation examination by those performing the evaluation, and to the taking of medical history information and the recording of that history and the findings and comments pertaining to the student athlete on the forms attached hereto by those practitioners performing the examination. As parent or legal guardian, I/We remain fully responsible for any legal responsibility which may result from any personal actions taken by the above named student-athlete.

Name of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

**INSURANCE COVERAGE**

I/We understand that medical bills related to athletic injury are the responsibility of the parent/guardian. Occasionally, student athletes are injured during practices or games and the school needs to ascertain that the parent/guardian has medical insurance in order to cover expenses if an injury occurs.

Please check one of the following and complete the information related to your child's insurance coverage (you may opt to choose more than one). EVERY ATHLETE MUST HAVE INSURANCE TO PARTICIPATE.

\_\_\_\_\_ I/We have personal insurance on (student-athlete's name) \_\_\_\_\_.

\_\_\_\_\_ I/We wish to purchase athletic insurance on (student-athlete's name) \_\_\_\_\_.

Please choose from coverage shown (Benefit information is available in the front office):

School-Time Only Plan

Economy Plan - \$8.00 \_\_\_\_\_ Basic Plan - \$16.00 \_\_\_\_\_ Deluxe Plan - \$24.00 \_\_\_\_\_

24-Hour Plan *without* Extended Dental Benefits

Economy Plan - \$44.00 \_\_\_\_\_ Basic Plan - \$88.00 \_\_\_\_\_ Deluxe Plan - \$132.00 \_\_\_\_\_

24-Hour Plan *with* Extended Dental Benefits

Economy Plan - \$49.00 \_\_\_\_\_ Basic Plan - \$98.00 \_\_\_\_\_ Deluxe Plan - \$147.00 \_\_\_\_\_

High School Football Plan

Economy Plan - \$40.00 \_\_\_\_\_ Basic Plan - \$80.00 \_\_\_\_\_ Deluxe Plan - \$120.00 \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_



# Sumner County Schools

**Benny Bills, Director of Schools**  
**695 East Main Street Gallatin, TN 37066-2472**  
**Phone: (615) 451-5200 Fax: (615) 451-5216**

## TRANSPORTATION TO AND FROM EXTRA-CURRICULAR ACTIVITIES

The Sumner County Board Of Education cannot provide transportation to all off campus extra-curricular activities (including but not limited to athletic events, practice, club and student organization competitions or events) in school owned vehicles operated by school personnel. Student may be transported by parents or other students with parental consent.

My child \_\_\_\_\_ participates in the following extra-curricular activities:

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I am aware that my child may be transported by non-school personal in non-school vehicles. My child may be responsible for getting himself/herself to various off-campus sites for the above activities. I understand that it may be my responsibility as parents/ guardian of \_\_\_\_\_ to arrange for appropriate transportation to and from these activities, and that in doing so I accept any risk involved.

If I as a parent/guardian transport students in my personal vehicle, or if my child transports other students in his/her personal vehicle, I understand that my insurance is the primary coverage for the students while in a personal vehicle. I also understand that I am responsible for reviewing with my child any restrictions which may be place on his/her driver's license that may affect in the number of student he/she may transport.

I have read the above and discussed with my child. By signing below, I acknowledge my responsibility to arrange appropriate transportation for my child to and from extra-curricular activities if not provided by the school.

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

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**GALLATIN HIGH SCHOOL**  
**Gallatin, Tennessee**

**CONSENT TO PERFORM URINALYSIS FOR DRUG TESTING**

I hereby consent to have a sample of my urine collected and tested for the presence of drugs in accordance with the Gallatin High School Department of Athletics Drug Testing Policy and Procedures if requested by school officials.

I understand that this testing will occur at such time or times as deemed appropriate by the team physician, head coach, principal, athletic director, or certified athletic trainer. I understand that my urine samples will be sent only to a licensed medical laboratory for actual testing and that the samples will be coded to provide confidentiality.

I hereby authorize the release of such urine testing results to the team physician, head coach, principal, athletic director, certified athletic trainer, and other high school officials as deemed appropriate. I understand that these results will also be made available to me.

I hereby authorize the release of the results of such testing to my parent(s)/guardian(s) upon receipt by the high school of a specific request by my parent(s)/guardian(s).

I understand that I am free to withdraw from this consent for urinalysis testing however, I also understand that should I refuse to submit to this consent at the time requested, I will not be permitted to participate in any athletic program until such time as my head coach and school administration shall deem appropriate.

I understand that before such a test would take place, my parents and I would have an opportunity to read and to understand the Gallatin High School Drug Education and Testing Policy and Procedures.

I hereby release the Sumner County Board of Education and Gallatin High School from any legal responsibility or liability for the release of such information and records authorized by this form.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student-Athlete Signature

\_\_\_\_\_  
Parent(s)/Guardian(s) Signature  
*(Necessary if Student-Athlete is a minor)*

**Gallatin High School  
Gallatin, Tennessee**

**ATHLETIC DRUG EDUCATION AND TESTING POLICY AND PROCEDURES**

**PURPOSE:**

Gallatin High School is concerned with the physical well being of its students, including those who participate in athletics. While the misuse of drugs is a potential problem for all students, unique pressures and risks exist for the student-athletes, and their use of drugs will not be tolerated. The term “student-athlete” includes members of any interscholastic sport or activity under the direction of the athletic department for the purposes of the Gallatin High School Drug Education and Testing Policy and Procedure.

The primary purposes of the drug education and testing policy and procedures for student-athletes are:

1. To employ education, testing, and counseling to deter drug use; and where deterrence is unsuccessful, to terminate participation in athletics.
2. To educate those students on the physiological and psychological dangers inherent in the misuse of drugs and alcohol.
3. To protect those students from the health related risks inherent the misuse of drugs and alcohol.
4. To protect those students, and others, from whom they compete, from potential injury because of the misuse if drugs and alcohol.
5. To remove the stigma of substance abuse from those student-athletes who do not misuse and/or abuse drugs or alcohol.
6. To provide a testing program to identify student-athletes who are improperly using drugs and to assist them, through education and counseling before they injure themselves or others or become physiologically or psychologically dependent.
7. To reassure athletes, parent, and the community that the health and academic progress of each of its student-athletes is Gallatin High School’s primary goal.

**DRUG TESTING PROCEDURE:**

Student-athletes will be subject to testing for the use and/or abuse of illegal or controlled substances as well as prescription and over-the-counter substances, drugs, or medications. Student-athletes who are under the care of a physician and must take a prescribed medication must provide documentation from that physician for the team physician. This should demonstrate a documented medical history indicating a need for the regular use of that medication as a part of ongoing care.

Testing will be accomplished by the analysis of urine specimens, or other recognized analytical procedures, obtained from the student under the direction of the coach, certified athletic trainer or team physician. The testing procedures will ensure that the specimen being analyzed is identified with the appropriate student and that the purity of that sample is maintained. The collector and/or school official may take more invasive steps to ensure the student-athlete does not alter the specimen. A professional laboratory selected by the team physician will conduct all chemical analyses. The parent(s)/guardian(s) or student-athlete will incur the expense required of any secondary testing following a positive test result payable to Gallatin High School.

## **FREQUENCY OF TESTING:**

1. All athletes will be subject to random drug testing throughout their athletic career.
2. All past activities will be subject to further drug testing throughout their athletic career.
3. An athlete can be tested whenever medically warranted.

## **TEST RESULTS:**

The following results of the drug tests will be forwarded to the team physician and the following action will be taken:

1<sup>st</sup> Positive: The head coach, principal, athletic director, certified athletic trainer, parent(s)/guardian(s), and student-athlete will be notified. The athlete will be suspended immediately from all practices, competitions, and participation in any scheduled athletic activity for a period of thirty (30) days beginning with the date the test results are received. If the test results are received in the “off-season”, a subsequent fifteen (15) day suspension will begin at the start of the first official practice of their next sport season.

The student-athlete and parent(s)/guardian(s) will meet with the team physician and/or the head coach, athletic director, certified athletic trainer concerning the risk of drug use, assistance that is available and the consequences of any subsequent drug test. In addition, the student-athlete will attend three (3) counseling sessions with the STARS counselor. The STARS counselor will make recommendations based on their assessment if successful completion of a drug-abuse counseling program is essential.

The student-athlete will be subject to periodic retesting throughout the suspension as well as the remainder of their athletic career to evaluate indication of further use. The student-athlete must apply to the Drug Education and Testing Committee for the reinstatement of eligibility for participation, practice, and competition at the end of the thirty (30) day period and only after negative testing prevails. The athlete may be subject to additional sanctions as violations of team policies by the head coach of their respective sport(s).

2<sup>nd</sup> Positive: A positive drug test at any time after a thirty (30) day suspension for a first positive will constitute a second positive. The head coach, principal, athletic director, certified athletic trainer, parent(s)/guardian(s), and student-athlete will be notified of the positive test results. The student-athlete will be suspended from all practices, competitions, and participation in any scheduled athletic activity for a period of one (1) year beginning with the date the test results are received.

The student-athlete and parent(s)/guardian(s) will meet with the team physician and/or the head coach, athletic director, certified athletic trainer concerning assistance that is available and the consequences of any subsequent drug test.

Application for the reinstatement may be considered the end of the one (1) year period and only after negative testing prevails. Successful completion of a drug-abuse counseling program will be strongly considered in addition to negative testing results.

3<sup>rd</sup> Positive: A positive drug test at any time after a one (1) year suspension for a first positive will constitute a third positive. The head coach, principal, athletic director, certified athletic trainer, parent(s)/guardian(s), and student-athlete will be notified of the positive test results. The athlete will lose the privilege of any further participation in the athletic program in any capacity for the remainder of his/her high school career. Application for the reinstatement will not be considered.

Violation/Refusal: A student-athlete who attempts to alter a sample, or otherwise provides an invalid sample, or who refuses to provide a sample as requested according to the program will be considered "positive" for the test date. He/she will then be handled according to the stated consequences, and the parent or guardian will be notified.

### **EDUCATION:**

1. At the time of their initial participation and annually thereafter, the student-athletes will be advised in writing of the purposes and procedures of the drug education and testing program.
2. Educational seminars on drug and alcohol abuse will be made available to all athletes and will be presented by professional and/or experienced drug educators or counselors.

### **SUPERVISION AND EVALUATION:**

The Drug Education and Testing Committee will have overall supervisory responsibility for this program. The Committee will consist of the principal, the athletic director, the school nurse, the certified athletic trainer, the team physician, the STARS counselor, and coaches selected in a manner determined by the principal or designee.

The committee will hear all applications for reinstatement. A minimum of three (3) committee members must be present for any vote regarding reinstatement. A vote by proxy or in absentia is not permissible. All decisions of the committee will be final, and the athlete and parent(s)/guardian(s) must agree to accept such decisions.

Meeting annually, the Drug Education and Testing Committee will make an evaluation of the program. The evaluation will include the effectiveness of the educational counseling program, procedural safeguards, and testing procedures.