Forsyth County Physical Form

Student Name:	
School:	





Physical Expiration Date (for office use only):

HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Name					Date of birth		
ex	Age	Grade S	chool _		Sport(s)		
Madiainaa	and Allauniaa.	Diagon list all of the properintian and a	ior the ee	untor m	andicines and cumplements (barbal and nutritions)) that you are currently	takina	
wearcines	and Allergies:	Please list all of the prescription and o	/er-tne-co	unter m	nedicines and supplements (herbal and nutritional) that you are currently	taking	
Do you have	e any allergies?	☐ Yes ☐ No If yes, please i	dentify sn	ecific al	leray helow		
☐ Medicin		□ Pollens	donary op	oomo ai	☐ Food ☐ Stinging Insects		
xolain "Yes	" answers below	. Circle questions you don't know the	answers 1	to.			
GENERAL QU		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Yes	No	MEDICAL QUESTIONS	Yes	No
		restricted your participation in sports for	100	110	26. Do you cough, wheeze, or have difficulty breathing during or		
any reaso					after exercise?		<u> </u>
		edical conditions? If so, please identify			27. Have you ever used an inhaler or taken asthma medicine?		
Other: _		nemia 🗆 Diabetes 🗀 Infections			28. Is there anyone in your family who has asthma? 29. Were you born without or are you missing a kidney, an eye, a testicle		-
	ı ever spent the nig	ht in the hospital?			(males), your spleen, or any other organ?		
	ı ever had surgery?				30. Do you have groin pain or a painful bulge or hernia in the groin area?		
HEART HEAL	LTH QUESTIONS A	BOUT YOU	Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?		
,	•	r nearly passed out DURING or			32. Do you have any rashes, pressure sores, or other skin problems?		
AFTER ex		art poin tightness or processes in your			33. Have you had a herpes or MRSA skin infection?		<u> </u>
	ring exercise?	ort, pain, tightness, or pressure in your			34. Have you ever had a head injury or concussion?		ــــــ
	_	r skip beats (irregular beats) during exercise	e?		35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
		hat you have any heart problems? If so,			36. Do you have a history of seizure disorder?		
	that apply: blood pressure	☐ A heart murmur			37. Do you have headaches with exercise?		
☐ High	cholesterol asaki disease	☐ A heart infection Other:			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
	ctor ever ordered a	test for your heart? (For example, ECG/EKG	,		39. Have you ever been unable to move your arms or legs after being hit or falling?		
		eel more short of breath than expected			40. Have you ever become ill while exercising in the heat?		
during ex	kercise?				41. Do you get frequent muscle cramps when exercising?		
	ı ever had an unex				42. Do you or someone in your family have sickle cell trait or disease?		<u> </u>
12. Do you go during ex		ort of breath more quickly than your friends			43. Have you had any problems with your eyes or vision?		
		BOUT YOUR FAMILY	Yes	No	44. Have you had any eye injuries?		
13. Has any f	family member or r	relative died of heart problems or had an			45. Do you wear glasses or contact lenses?		-
		sudden death before age 50 (including	,		46. Do you wear protective eyewear, such as goggles or a face shield? 47. Do you worry about your weight?		
	•	accident, or sudden infant death syndrome)' have hypertrophic cardiomyopathy, Marfan			48. Are you trying to or has anyone recommended that you gain or		
syndrome	e, arrhythmogenic	right ventricular cardiomyopathy, long QT			lose weight?		
	e, short QT syndror ohic ventricular tacl	ne, Brugada syndrome, or catecholaminerg ovcardia?	С		49. Are you on a special diet or do you avoid certain types of foods?		
		have a heart problem, pacemaker, or			50. Have you ever had an eating disorder?		<u> </u>
	d defibrillator?				51. Do you have any concerns that you would like to discuss with a doctor?		
-		ad unexplained fainting, unexplained			FEMALES ONLY		
	or near drowning?		Yes	No	52. Have you ever had a menstrual period?	-	
	• • • • •	to a bone, muscle, ligament, or tendon	162	NU	53. How old were you when you had your first menstrual period? 54. How many periods have you had in the last 12 months?		
,		ractice or a game?			Explain "yes" answers here		
18. Have you	ı ever had any brok	en or fractured bones or dislocated joints?			LAPIGIT YES GISWEIS HETE		
		that required x-rays, MRI, CT scan,					
	s, therapy, a brace, i ever had a stress	a cast, or crutches?					
		it you have or have you had an x-ray for ned	k				
		tability? (Down syndrome or dwarfism)					
22. Do you re	egularly use a brac	e, orthotics, or other assistive device?					
		e, or joint injury that bothers you?					
-		e painful, swollen, feel warm, or look red?					
25. Do you h	ave any history of j	uvenile arthritis or connective tissue diseas	e?				

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam						
Name				Date of birth		
	Λας	Grada	School			
26x	_ Aye	Grade	Scrioor	Sport(s)		
1. Type of dis	ability					
2. Date of dis						
3. Classificati	ion (if available)					
4. Cause of d	isability (birth, dise	ease, accident/trauma, other)				
5. List the spo	orts you are interes	sted in playing				
					Yes	No
6. Do you reg	ularly use a brace,	, assistive device, or prosthetic	?			
		or assistive device for sports				
		ssure sores, or any other skin	problems?			
_		Do you use a hearing aid?				
	ve a visual impairm					
		es for bowel or bladder function	on?			
		omfort when urinating?				
	nad autonomic dys					
			nermia) or cold-related (hypothermia) illne	SS?		
_	ve muscle spasticit	ty? es that cannot be controlled by	modication		-	
	· ·	es mai cannot be controlled by	medication?			
Explain "yes" a	inswers here					
Please indicate	if you have ever	had any of the following.				
					Yes	No
Atlantoaxial ins						
	stability n for atlantoaxial ii	nstability				
X-ray evaluatio		nstability				
X-ray evaluatio Dislocated joint Easy bleeding	n for atlantoaxial in	nstability				
X-ray evaluation Dislocated joint Easy bleeding Enlarged spleet	n for atlantoaxial in	nstability				
X-ray evaluation Dislocated joint Easy bleeding Enlarged spleed Hepatitis	n for atlantoaxial ii ts (more than one) n	nstability				
X-ray evaluatio Dislocated joint Easy bleeding Enlarged spleet Hepatitis Osteopenia or o	n for atlantoaxial ii ts (more than one) n osteoporosis	nstability				
X-ray evaluatio Dislocated joint Easy bleeding Enlarged spleet Hepatitis Osteopenia or o Difficulty control	n for atlantoaxial it ts (more than one) n osteoporosis olling bowel	nstability				
X-ray evaluatio Dislocated joint Easy bleeding Enlarged spleet Hepatitis Osteopenia or o Difficulty control Difficulty control	n for atlantoaxial it ts (more than one) n osteoporosis olling bowel olling bladder					
X-ray evaluatio Dislocated joint Easy bleeding Enlarged spleet Hepatitis Osteopenia or o Difficulty contro Numbness or ti	n for atlantoaxial in ts (more than one) n osteoporosis olling bowel olling bladder ingling in arms or I	hands				
X-ray evaluatio Dislocated joint Easy bleeding Enlarged spleet Hepatitis Osteopenia or o Difficulty contro Numbness or ti Numbness or ti	n for atlantoaxial in ts (more than one) n osteoporosis olling bowel olling bladder ingling in arms or h	hands				
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X-ray evaluatio Dislocated joint Easy bleeding Enlarged spleet Hepatitis Osteopenia or o Difficulty contro Numbness or ti Numbness or ti Weakness in ar Weakness in le Recent change Recent change Spina bifida Latex allergy	n for atlantoaxial in ts (more than one) n osteoporosis olling bowel olling bladder ingling in arms or thingling in legs or ferms or hands ags or feet in coordination in ability to walk	hands				
X-ray evaluatio Dislocated joint Easy bleeding Enlarged spleet Hepatitis Osteopenia or o Difficulty contro Numbness or ti Numbness or ti Weakness in ar Weakness in le Recent change Recent change Spina bifida Latex allergy	n for atlantoaxial in ts (more than one) n osteoporosis olling bowel olling bladder ingling in arms or thingling in legs or ferms or hands ags or feet in coordination in ability to walk	hands				
X-ray evaluatio Dislocated joint Easy bleeding Enlarged spleet Hepatitis Osteopenia or o Difficulty contro Numbness or ti Numbness or ti Weakness in ar Weakness in le Recent change Recent change Spina bifida Latex allergy	n for atlantoaxial in ts (more than one) n osteoporosis olling bowel olling bladder ingling in arms or thingling in legs or ferms or hands ags or feet in coordination in ability to walk	hands				
X-ray evaluatio Dislocated joint Easy bleeding Enlarged spleet Hepatitis Osteopenia or o Difficulty contro Numbness or ti Weakness in ar Weakness in le Recent change Recent change Spina bifida Latex allergy Explain "yes" a	n for atlantoaxial in ts (more than one) n osteoporosis olling bowel olling bladder ingling in arms or h ingling in legs or ferms or hands rgs or feet in coordination in ability to walk	hands	s to the above questions are complete	and correct.		
X-ray evaluatio Dislocated joint Easy bleeding Enlarged spleet Hepatitis Osteopenia or o Difficulty contro Numbness or ti Weakness in ar Weakness in le Recent change Recent change Spina bifida Latex allergy Explain "yes" a	n for atlantoaxial in ts (more than one) n osteoporosis olling bowel olling bladder ingling in arms or h ingling in legs or ferms or hands rgs or feet in coordination in ability to walk	hands	s to the above questions are complete	and correct.		

PHYSICAL EXAMINATI	ON	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, 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 suppleme • Have you ever taken any supplements to help you gain or lose weight or improve • Do you wear a seat belt, use a helmet, and use condoms? 2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).		mance?		
EXAMINATION				
Height Weight	☐ Male	☐ Female		
BP / (/) Pulse	Vision		L 20/	Corrected □ Y □ N
MEDICAL	VISIOII	NORMAL	L 20/	ABNORMAL FINDINGS
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnorarm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)	dactyly,	NORMAL		ADNONWAL FINDINGS
Eyes/ears/nose/throat Pupils equal Hearing				
Lymph nodes				
Heart a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI) Pulses				
Simultaneous femoral and radial pulses				
Lungs				
Abdomen				
Genitourinary (males only) ^b				
Skin HSV, lesions suggestive of MRSA, tinea corporis				
Neurologic ^c				
MUSCULOSKELETAL				
Neck				
Back				
Shoulder/arm				
Elbow/forearm Wrist/hand/fingers				
Hip/thigh				
Knee				
Leg/ankle				
Foot/toes				
Functional Duck-walk, single leg hop				
"Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. "Consider GU exam if in private setting. Having third party present is recommended. "Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussi Cleared for all sports without restriction Cleared for all sports without restriction with recommendations for further evaluations."		ent for		
□ Not cleared				
☐ Pending further evaluation				
☐ For any sports				
For certain sportsReason				
Recommendations				
I have examined the above-named student and completed the preparticipation participate in the sport(s) as outlined above. A copy of the physical exam is on r tions arise after the athlete has been cleared for participation, the physician may explained to the athlete (and parents/guardians).	ecord in my	office and can be ma	de available to	the school at the request of the parents. If condi-
Name of physician (print/type)				Date

Address _

Signature of physician _

_, MD or D0

Phone ___

CLEARANCE FORM

Name Se	X LI MI LI F Age Date of dirth
☐ Cleared for all sports without restriction	
$\hfill\Box$ Cleared for all sports without restriction with recommendations for further evaluations	ion or treatment for
□ Not cleared	
□ Pending further evaluation	
☐ For any sports	
□ For certain sports	
Recommendations	
Ticoniniciaations	
I have examined the above-named student and completed the prepartic clinical contraindications to practice and participate in the sport(s) as and can be made available to the school at the request of the parents.	outlined above. A copy of the physical exam is on record in my office
the physician may rescind the clearance until the problem is resolved a (and parents/guardians).	
Name of physician (print/type)	Date
Address	
Signature of physician	
EMERGENCY INFORMATION	
Allergies	
Other information	

FORSYTH COUNTY SCHOOL SYSTEM ATHLETIC PARTICIPATION FORM

FORSYTH COUN	TY ATHLE	TICS	S PERMISSION FORM		N FORM	
Student - Athlete:(Please Print)		Name of Parent/Gu	ardian:(F	Please Print)	
Street Address:			School:			Grade: CIRCLE ONE
City ii	Ctata	7:0.	Date of Birth:		7 8 9 10 11 12	
City:	State:	Zip:	Date of Birth:		Phone: Home - Work -	
In the event of	f emergency	nlease	give the hest nerso	n and m	nethod to c	ontact in the box provided.
Name:	emergency,		ationship:	Phon		Alt #:
Request for Permiss participate in interschol		unders	signed student and t			t/guardian, apply for permission to
[] Baseball / Softball	[] Cross Co	untry	[] Lacrosse	[]Ten	nnis	[] Gymnastics
[] Basketball	[] Football		[] Soccer	[] Tra	ack & Field	[] Other:
[] Cheerleading	[] Golf		[] Swimming	[]Wre	estling	
General Requirements- We have read and discussed the general requirements for athletic eligibility. We understand that additional questions or specific circumstances should be directed to our student's coach, athletic director or principal. We understand that the FC Athletic Guidelines are available through the county website for review. 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 FCSS 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 FCSS can eliminate the risk of injur sports. Injuries may and do occur. Sports injuries can be severe and in some cases may result in permanent disabilit even death. We freely, knowingly, and willfully accept and assume the risk of injury that might occur from participatio athletics.			may result in permanent disability or hat might occur from participation in			
FCSS, its athletic coad	ches and other	er empl	byees free, harmless	and inc	demnified fr	etics, we agree to release and hold om and against any and all claims, suffer from participation in athletics.
Insurance- FCSS requires parents to provide information pertaining to medical insurance coverage for all student athletes. Parents have the option to purchase school insurance (please see school athletic director) or to maintain coverage under parental insurance provider.						
Check One: [] School Accident Insurance [] Name of Other			of Other Insurance Compa	iny: Po	olicy No:	
Address:			G	Group No:		
correct. We agree to a FCSS is unable to con	abide by state tact the parer nt's injury. Tre	e and lo nt, we gr eatment	cal rules. If the stude rant FCSS permissior may include, but is n	ent-athle n and au ot limited	te is injured othority to oled to first aid	nation provided by us on this form is d while participating in athletics and otain necessary medical care and/or, CPR, medical or surgical treatment care or treatment.
We, the undersigned athletic participation			t, have read this do	cument	and unde	rstand all of the expectations for
Student:					Date:	
Parent/Guardian:				Date:		

"BLANKET" PERMISSION TO PARTICIPATE IN A SERIES OF SCHOOL SPONSORED FIELD TRIPS

Sport:	School Yea	r: Scho	ool:
ticular area of study or activi	ty. I understand rict). In the even	chestra, chorus, and/or any sethat transportation may or ma	ent's Name-PLEASE PRINT): be al- eries of field trips related to one par- y not be provided by the Forsyth ed by the District, transportation will
arranges independent trans rector in advance, will be in School in the Forsyth Coun parent/guardian (see the he contest. A parent/guardian	sportation to an neligible to com ity provided tra ead coach). Athl must sign out t ngements for pr	event, without permission for the peter in that event. All team is insportation unless a Travel letes will only be released to he athlete from the coach at ivate transportation, they should be reased to the coach at ivate transportation, they should be reased to the coach at ivate transportation, they should be reased to the coach at ivate transportation, they should be reased to the coach at	ion with the team. Any athlete who from the coach and the Athletic Dimembers will return to their High Release form is completed by a their own parent/guardian from a the contest site. If a student and hall not hold the local school, offi-
	ents/guardians p		me of return, purpose, and supervi- Exceptions must be approved by the
			ent during the trip, I consent to the r treatment in his/her or their discre-
FCSS, its athletic coaches a	and other employ	yees free, harmless and inder	chletics, we agree to release and hold mnified from and against any and all tudent-athlete may suffer from partic-
NOTE: This form must b	be signed by	student if the student is	18 years of age or older.
Name of Student (PLEASE PRIN	NT)	Signature of Student	Date
Name of Parent/Guardian (PLE	—— ASE PRINT)	Signature of Parent/Guardian	 n Date

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.
- c) It is mandatory that every coach in each GHSA sport participate in a free, online course on concussion management prepared by the NFHS and available at www.nfhslearn.com at least every two years beginning with the 2013-2014 school year.
- d) Each school will be responsible for monitoring the participation of its coaches in the concussion management course, and shall keep a record of those who participate.

I HAVE REAL	D THIS FORM AND I UNDERSTAN	D THE FACTS PRESENTED IN IT.
SIGNED:		
	(Student)	(Parent or Guardian)
DATE:		