MEADOWS
SPORTS MEDICINE

Welcome!
The staff at Meadows Regional Medical Center would like to welcome you to the new school year. We pray that it will be an exciting and safe year for your student athlete. Meadows Regional has been contracted with your school to be the Official Sports Medicine Provider. What this means is Meadows provides a Certified Athletic Trainer (ATC) - at no charge - to your child's school. The ATC is a certified and licensed health care provider who collaborates with physicians to optimize activity and participation of the physically active. www.NATA.org

Sports Medicine Forms
Before any treatment can be provided, the athlete must have his/her parent sign and return the Sports Medicine parental consent form which authorizes the Certified Athletic Trainers to render care. These forms are given to each athlete prior to the pre-participation physical and must be returned before the athlete will be allowed to participate. The form also authorizes emergency consent to treat in the event a parent or guardian cannot be reached. **A COPY - FRONT AND BACK - OF THE STUDENT'S INSURANCE CARD MUST ACCOMPANY THESE FORMS.**

Concussion Policy
Beginning Jan. 1, 2014, all public and private schools are required to create a concussion policy. A copy of the Concussion Policy is on file at the school. You are provided an educational sheet with this packet. **Sign and detach the bottom portion of the form and return the signed portion with the physical forms. Your child will not be able to participate without the signed portion on file at the school.**

Physician Referrals
Should an injury or illness warrant additional treatment and care, the Meadows Athletic Trainer can assist in the referral process. We have medical providers already established for the various medical conditions that may arise. We will refer you to these medical providers automatically unless you state you have other preferences. Please do not seek medical attention (unless an emergency) without first notifying the Athletic Trainer. In most cases, when the Meadows athletic trainer calls the orthopedic physician directly, the athlete will be seen by that doctor within one to two days. Athlete may always be taken to location of preference by the parent. Any athlete who sees a physician for an injury sustained while participating in a sport or activity at the school must present a signed physician release form to the athletic trainer. Any athlete who does not present a physician release to the athletic trainer will not be allowed to resume practice or participate in games. **The parent or guardian must always accompany the athlete to the first doctor appointment.**

National Athletic Trainers' Association
Health Care for Life & Sport

STOP
PARTICIPATING

MEADOWS SPORTS MEDICINE

Dear Parent:

Meadows Sports Medicine, under Meadows Healthcare Resources, provides athletic trainer coverage (at no cost) to your student'(s) school. Part of our service is providing annual athletic physical exams.

- A $10.00 fee per student is charged for the exam. The cost of the exam is placed in an account for the specific school to provide for athletic health care equipment and supplies and the cost of ImPACT baseline concussion testing.
- The time, place, and date for each school will be provided to the team coaches.
- **All examinees must wear shorts, t-shirts, socks, and tennis shoes.**
- **All paperwork (INCLUDING MEDICAL HISTORY) must be completed and turned in to the school prior to the exams.**
- **Sign a copy of the Concussion Fact Sheet and keep a copy for your records.**

As the parent/guardian of _____, my child or ward (hereinafter, collectively, "child"), I hereby give my permission to the following:

1) Examination of my child by Meadows Sports Medicine healthcare personnel.
2) The information contained in this physical examination is used exclusively for the participation of the athlete in his/her school sports activity and will ONLY be released to the following:
    a) A bona fide representative of Meadows Sports Medicine for research purposes.
    b) To a physician administering emergency treatment to my child.
    c) To a hospital, health care facility, or emergency care facility administering treatment to my child.
    d) The records will be released to a school authority to be kept on file at the school.

DATE: _____

SIGNATURE: _____
Parent or Legal Guardian

PRINT NAME: _____
Parent or Legal Guardian

MEADOWS SPORTS MEDICINE

Athlete Emergency Information
Please print except for signatures

School_____

Name_____Year _____ Birthdate _____
Parent/Guardian: (father)_____ (mother)_____
Home phone:_____ Home phone:_____
Work/cellphone:_____ Work/cellphone:_____
Athlete's home address_____
Zip Code_____ Lives with (mother) (father) (other_____)

PRIVATE (PRIMARY) INSURANCE
Ins. Co. Name _____Pre-authorization phone # _____
Insurance Company Address _____
City_____ State_____ Zip Code_____
Name of
insured_____
Contract/Policy # _____ Group # _____ Other # _____
My son / daughter is covered by the above insurance policy. __Yes __No Effective date_____
Known Allergies (drug,food,insect,etc...) _____
Special Medical Problems _____
Medications (inhaler,insulin, etc...) _____
The athletic trainer or coach may provide the following over the counter medicines to my child as necessary: antacid, Tylenol(acetaminophen),Advil/Motrin(ibuprofen), Aleve. ____YES____NO
(initial)

Parent Guardian Consent to Treatment of Student Athletes

I, _____, the undersigned parent / guardian of

_____
Name of student

a minor, do hereby authorize the Meadows Athletic Trainer or school representative on my behalf to consent to any medical treatment deemed necessary by any licensed physician/surgeon in the event of illness or injury to the above named minor.

This consent to treat is intended to cover any illness or injury sustained while participating in any school athletic competition or practice, on or off campus, and while traveling to and from the event.

If, in the judgment of any representative of the school, the above named student needs immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by any physician, athletic trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school, Meadows Healthcare Resources, and any school representative from any claim by any person whomsoever on account of such care and treatment of said student. I hereby authorize any hospital, which has provided treatment to the above named student to surrender custody of that student to the athletic trainer or school representative upon completion of treatment.

These authorizations shall remain effective until the end of the 2016-2017 school year.

_____ _____
Parent / Guardian Date

A COPY OF THE MINORS INSURANCE CARD, FRONT AND BACK, MUST ACCOMPANY THIS FORM

Concussions

What you need to know

MEADOWS
SPORTS MEDICINE

What is the law?

Schools: House Bill 284, the Return to Play Act of 2013, requires all public and private schools to create a concussion policy that, at a minimum, includes these standards:

- Prior to the beginning of each athletic season, an information sheet that informs parents or legal guardians of the risk of concussions must be provided.
- If a youth athlete (ages 7 to 18) participating in a youth athletic activity exhibits signs or symptoms of a concussion, he must be removed from play and evaluated by a healthcare provider.
- Before a youth athlete can return to play, he must be cleared by a healthcare provider trained in the management of concussions.

Recreational Leagues: HB 284 requires recreational leagues to provide an information sheet on the risks of concussion at the time of registration to all youth athletes' (ages 7 to 18) parents or legal guardians.

What is a concussion?

It is a type of brain injury caused by trauma. It can be caused by a hard bump on or blow to or around the head, which causes the brain to move quickly inside the head. You do not have to lose consciousness to have a concussion. If a concussion is not properly treated, it can make symptoms last longer and delay recovery. A second head trauma before recovery could lead to more serious injuries.

What are the signs and symptoms?

There are many signs and symptoms linked with concussion. Your child may not have any symptoms until a few days after the injury. Signs are conditions observed by other people and symptoms are feelings reported by the athlete.

Signs observed by others

- Appears dazed or stunned
- Forgets plays
- Is unsure of game or opponent
- Moves clumsily
- Answers questions slowly
- Shows behavior or personality changes

Symptoms reported by athlete

- Headache
- Nausea
- Dizziness
- Fuzzy vision
- Feeling foggy
- Concentration problems

For a full list of signs and symptoms visit choa.org/concussion.

What should you do if you suspect a concussion?*

- Do not let your child play with a head injury.
- Check on your child often after the injury for new or worsening signs or symptoms. If the symptoms are getting worse, take him to the nearest Emergency Department.
- Take your child to the doctor for any symptom of a concussion.
- Do not give your child pain medications without talking to your child's doctor.
- Your child should stop all athletic activity until his doctor says it is OK. Your child must stay out of play until he is cleared by a licensed healthcare provider.
- Educate your child on concussions and why he cannot play until the symptoms are gone. Your child will need a gradual return to school and activities.
- Tell your child's coaches, school nurses and teachers if he has a concussion.

In case of an urgent concern or emergency, call 911 or go to the nearest emergency department right away.

Warning signs

Call your child's doctor right away if he has:

- New signs that his doctor does not know about
- Existing signs that get worse
- Headaches that get worse
- A seizure
- Neck pain
- Tiredness or is hard to wake
- Continued vomiting
- Weakness in the arms or legs
- Trouble knowing people or places
- Slurred speech
- Loss of consciousness
- Blood or fluid coming from nose or ear
- A large bump or bruise on scalp, especially in infant younger than 12 months

Where can I find more information?

Visit choa.org/concussion for return to school and activities guidelines, educational videos and general concussion information.

This is general information and not specific medical advice. Always consult with a doctor or healthcare provider if you have questions or concerns about the health of a child. This piece was created by the concussion team at Children's Healthcare of Atlanta.

It is the policy of Meadows Sports Medicine that athletes cannot practice or compete in activities until this form is signed and returned. By signing this form, you acknowledge that you have received the fact sheet on concussions.

Athlete's Signature _____ Date _____

Athlete's Printed Name _____

Athlete's Parent/Guardian Signature _____ Date _____

Athlete's School _____ Grade _____

MEADOWS
SPORTS MEDICINE

_____ _____
(name of student) (date of birth)

MEDICAL RELEASE

I give permission for the school official, chaperon or representative of Meadows Regional Medical Center (MRMC) involved in the activity with my child to seek medical aid, render first aid if such attention is necessary in the sole discretion of said person involved. In case of emergency and when I cannot be immediately reached by telephone or otherwise, I give permission to the physician selected by school officials to hospitalize, secure proper treatment, order injections, anesthesia or surgery for my child.

ACKNOWLEDGMENT OF RISK

Both the student and the parent/guardian should read this statement carefully. You should be aware that playing or practicing to play or helping to play or helping with or participating in any manner in any sport can be a dangerous activity involving risks of injury. The dangers and risks of playing, practicing to play, helping or participating in sports include but are not limited to death, serious neck, head and 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, and ligaments, tendons and other aspects of Musculoskeletal system and serious impairment to 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 team rules and obey such instruction.

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

_____

Parent/Guardian Date

MEADOWS

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Over the Counter Medications

Below is a list of medications that are usually kept in stock. Medications will be dispensed on an as needed basis determined by the Certified Athletic Trainer on staff in single doses as recommended by the product labels or as directed by a physician. Your **initials** in the yes box as well as your **signature** at the bottom of the page will indicate your permission to dispense that specific medication to your child. If your child may not have a particular medication, please **initial** the no box.

Medication	Yes	No
Ibuprofen, generic form of Advil, two 200 mg pills per packet		
Acetaminophen, generic form of Tylenol, two 325 mg pills per packet		

If your child has any drug allergies or drug interaction warnings please specify:

_____

_____

_____

I hereby give permission for my child, _____, to receive over the counter medication, as indicated above, from the Certified Athletic Trainer on staff at Vidalia High School.

_____ _____

Signature of Parent or Legal Guardian Date

PREPARTICIPATION PHYSICAL EVALUATION
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.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
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 (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. 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.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION
THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability	
2. Date of disability	
3. Classification (if available)	
4. Cause of disability (birth, disease, accident/trauma, other)	
5. List the sports you are interested in playing	

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

_____

_____

_____

_____

_____

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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, 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 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 (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
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		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____
  - Reason _____

Recommendations _____

_____

_____

_____

_____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

VIDALIA HIGH SCHOOL
DRUG SCREENING PROGRAM

Goals of the VHS Screening Program

- Give students another opportunity to stay away from drugs and anyone who uses drugs.
- Produce student-athletes who serve as a positive role model, influencing their peers to make healthy and responsible choices.
- Anyone who drives while under the influence of drugs or alcohol endangers the lives of themselves and others. Through the drug screening program, we seek to encourage students to remain substance-free and establish appropriate habits at an early age.
- Deter the use of illegal drugs in our community.
- Identify any student who may be using drugs and to identify the drugs as well as to provide referrals for counseling and treatment.

The complete Vidalia High School Drug Policy can be found on line at http://vidalia.ga.vch.schoolinsites.com/

By signing this form you are agreeing to and understanding all actions and consequences that will be taken under the Vidalia High School Drug Policy.

Print Student Name _____ _____

Student signature_____ Date ____

Parent signature_____ Date ____