

ATLANTA PUBLIC SCHOOLS ATHLETICS

Please read and complete each section of this document. Form must be completed before students are cleared to participate.

Part I PARENT CONSENT FOR ATHLETIC PARTICIPATION AND EMERGENCY MEDICAL TREATMENT

I, \_\_\_\_\_, parent or guardian, hereby gives consent for my child or ward, \_\_\_\_\_ to compete in middle school or high school athletics for \_\_\_\_\_ Middle/High School. Should at any time I desire said student to refrain from participating, I will notify the athletic director or head coach of said school in writing. I fully understand insurance coverage and limitations. Also, in consideration of my son's/daughter's opportunity to participate in interscholastic activities, I hereby consent to emergency medical treatment, hospitalization or other medical treatment as may be necessary for the welfare of the above-named child, by a physician, qualified nurse, and/or hospital, in the event of injury or illness during all periods of time in which the student is away from his/her legal residence as a member of an interscholastic activity team or group, and hereby waive on behalf of myself and the above-named child any liability of The Atlanta Board of Education, any of its agents or employees, arising out of such medical treatment.

WARNING: BY ITS NATURE, PARTICIPATION IN INTERSCHOLASTIC ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CATASTROPHIC, INCLUDING PERMANENT PARALYSIS FROM THE NECK DOWN OR DEATH. PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM.

By signing this Form, I acknowledge that I have read and understand this warning and consent for participation and emergency medical treatment.

Parent's or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Part II PLEASE CHECK ONE OF THE FOLLOWING INSURANCE OPTIONS

[ ] OPTION NO. 1: I hereby certify that my child or ward, (name) \_\_\_\_\_ is a member of a group or to her private hospital and medical plan and/or Medicaid and is covered by that policy or plan for injuries, which may occur from athletic participation. Coverage there under is provided by (name of Company) \_\_\_\_\_, under Policy No. \_\_\_\_\_. I understand and affirm that, in light of my selection of this Option, the Atlanta Board of Education has relied upon this certification by me in allowing my child or ward to participate in middle/high school athletics. I will notify the Atlanta Board of Education in writing of any changes in coverage within ten (10) days of said change.

[ ] OPTION NO. 2: I hereby certify that my child or ward, \_\_\_\_\_ is not a member of a group or other private hospital and medical plan, including Medicaid, and is not covered by any policy or plan for injuries which may occur from athletic participation. I understand the Atlanta Public School System will make available limited excess medical coverage as per insurance outline/overview for my child or ward in consideration for premium in the amount of \$12.00 for Varsity, Jr. Varsity and Middle School Athletics paid by me on behalf of my child or ward. I further understand that no payment will be made for any medical expense incurred after the policy period expires on June 30, 20\_\_\_\_, regardless of the date of my child's/ward's injury. All medical expenses incurred must be submitted no later than June 1, 20\_\_\_\_. All medical expenses are excess over any other valid insurance including Medicaid. I understand that I am responsible for the filing of any and/or all medical claims. I have read and understand the benefits and exclusions.

NOTE: THERE CAN BE NO PARTICIPATION IN THE ATHLETIC PROGRAMS OF THE ATLANTA PUBLIC SCHOOLS UNLESS THE STUDENT IS COVERED BY A GROUP PLAN, MEDICAID OR IN THE EVENT OF NO INSURANCE, THE LIMITED EXCESS BENEFIT PLAN MADE AVAILABLE THROUGH THE ATLANTA PUBLIC SCHOOLS.

I understand and affirm my selection of this option.
Parent's or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Part III STUDENT MEDIA RELEASE FORM

I hereby agree to allow my child, \_\_\_\_\_, to be photographed, videotaped and/or voice recorded and for his/her name, image, likeness and voice to be used for APS approved photographs, videos, publications, news media and web pages for special projects or publicity aimed at promoting school activities and sound teaching practices.

I am aware that my child may be asked a variety of questions concerning school and school-related activities and programs, and that the contents of the interview may be published or aired publicly. I understand that my child will be under the supervision of a school staff member during the interview or photo session, though not if the photographs or video or voice recordings are part of a general background scene in which my child is not identified.

My child reserves the right to refuse to answer any questions or participate in any discussions that make him/her feel uncomfortable or embarrassed. Additionally, my child and/or the supervising school agent reserves the right to terminate the interview, photo or video session at any time if said activities cause embarrassment or discomfort to my child.

I understand that neither APS, nor the news media, has any obligation to air or publish the image, photos, videotape and/or voice of my child. I also understand that neither my child nor I will receive any monetary compensation for the rights granted herein. And I understand that my child's appearance or the use of his/her voice in any publication, photo or televised form does not confer any ownership rights on my child or me.

If by reason of my child's statements and actions in the interview, photos, images, videotape and/or voice recording, or the materials furnished to my child for the same, there is any claim or litigation involving any charge by third parties of violation or infringement of their right, I agree to indemnify and hold harmless Atlanta Public Schools, its staff and its licensees, and assigns from liability, loss or expenses arising from such claim or litigation.

Parent's or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_
2005



**Preparticipation Physical Evaluation**

**PHYSICAL EXAMINATION FORM**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body Fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ )

Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

	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.

Notes: \_\_\_\_\_

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

Address \_\_\_\_\_ Phone \_\_\_\_\_

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

**Preparticipation Physical Evaluation**

**CLEARANCE FORM**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Not Cleared for  All sports  Certain sports: \_\_\_\_\_ Reason: \_\_\_\_\_

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

**EMERGENCY INFORMATION**

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

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 \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Not Cleared for  All sports  Certain sports: \_\_\_\_\_ Reason: \_\_\_\_\_

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

**EMERGENCY INFORMATION**

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

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

Address \_\_\_\_\_ Phone \_\_\_\_\_

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

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