BETHESDA
ACADEMY
A HOME & SCHOOL FOR BOYS SINCE 1740

Consent for Participation in Physical Education, Sports and Work Experience

All students must have a physical on file for the current school term as well as this permission form for participation in Physical Education, Sports, and Work Experience Programming.

☐ **FULL PARTICIPATION** I understand that physical education is a class and includes physical activities. My son, _____ has permission and does not have any medical condition or needs that exempt him from participating fully in all such activities. I/We agree to hold Bethesda Academy, it's Board of Directors, its employees and authorized volunteers harmless should any mishap occur. I/We realize that Bethesda and Bethesda staff will do all possible to provide for the safety of my/our child. In the event of an accident in which my/our child is injured, I/we give my/our express consent for the Bethesda staff to obtain medical treatment and will bear all expenses incurred on behalf of my son.

By my signature on this document, I agree to the terms written above.

_____ _____

Parent/Guardian Date

☐ **LIMITED PARTICIPATION** Complete this section if your son has physician prescribed limitations to his physical exertion level. IT MUST HAVE A PHYSICIAN'S SIGNATURE if he cannot participate in regular physical activities. Please make us aware and complete the LIMITED PARTICIPATION section.

For reasons explained below physical activities for my/our child, _____, must be limited.

My/Our child has permission to participate within the guidelines set forth in the limitations prescribed below by his physician. I/We agree to hold Bethesda Academy, it's Board of Directors, its employees and authorized volunteers harmless should any mishap occur. I/We realize that Bethesda and Bethesda staff will do all possible to provide for the safety of my/our child. In the event of an accident in which my/our child is injured, I/we give my/our express consent for the Bethesda staff to obtain medical treatment.

The physician has prescribed these limitations:

_____

_____

_____

_____ _____

Physician Date

By my signature on this document I agree to the terms written above

_____ _____

Parent/Guardian Date

☐ **SPORTS PARTICIPATION** I hereby give consent for _____ to participate in _____.

List name of sports (football, basketball, track and field, baseball, archery, golf)

I give my permission for said student to travel on all athletic trips scheduled for his team. In granting this permission, I also assume full responsibility for any and all damage to person or property caused by my child.

I understand that by participating in interscholastic athletics, my son is exposing himself to the risk of serious injury. I give my permission and consent to Bethesda Day School athletic director, coach and/or staff to care for and provide appropriate medical treatment for my son in the event of injury.
In the event of an emergency, I prefer my son to receive treatment at _____.

Hospital Name

*Parent/Guardian Signature:*_____ *Date:*_____

☐ **WORK EXPERIENCE PARTICIPATION** I hereby give consent for _____ to in the Work Experience Program as part of the school day. All students will be evaluated based on participation, attitude, the student's work habits and any content material specific to the course. Students will receive a grade and elective credit for participation in the work program. It is our desire that the work experience provide opportunities for Bethesda students to know the importance of using critical thinking skills to complete a task, take pride in the work task they complete and form marketable skills for future employment.

Students will rotate through the following programs:

- ✓ **Wildlife Management**: Students will maintain the hatchery building, be involved with the reforestation of the lake area and manage the clearance acreage around the power lines.
- ✓ **Maintenance:** Students will maintain the general appearance of the campus grounds, learn such skills as changing a tire and oil in a vehicle, and assist in the set up for special events.
- ✓ **Organic Garden:** Students will cultivate, plant, harvest vegetable crops and participate in the set up and preparation for the weekly market.
- ✓ **Video Production:** Students will learn to operate video equipment, participate in the filming of live video on various jobs contracted by Comcast and Bethesda and produce a class project.

EXPECTATIONS for the students:

- Students are to meet their mentor in the assigned area.
- Students will dress out in appropriate work clothes. Wearing the school uniform is not acceptable.
- Class expectations will be enforced by each mentor. Tardiness to class, skipping, lack of participation will be dealt with according to the school's discipline policies.

*Parent/Guardian Signature:*_____ *Date:*_____

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MEDICATION WAIVER

I, _____, parent/legal guardian of _____, who is a student athlete at Bethesda Academy give permission to the Certified Athletic Trainer to dispense medicine to my son. I acknowledge different medicines have different purposes. Therefore, School staff and/or Athletic Trainer have my permission to disperse medicine according to signs and symptoms or specific problem/injury. Medications that may be available include name brand or generic Aleve, Tylenol, Ibuprofen, Pepto Bismol, Imodium, Tums, medi-lyte (or other electrolyte replacements). If there are any medications you do not wish for your son to take please list below. I also acknowledge certain medications may be contraindicated based on prescription drugs that my son takes on a daily basis, therefore I agree to notify the school office and/or Athletic trainer as soon as there are any changes in medication my son takes daily.

This document will serve as written permission to dispense OTC medicine as the Athletic Trainer sees fit, and has available. I acknowledge that these medications will only be dispersed in *emergency situations*. If the Certified Athletic Trainer or other medical personnel recommends that my son needs an over the counter medication multiple times per day, I agree that I will be responsible for providing this for him.

If my son requires any medication that is not OTC but needs to take during the day or while the athletic team may be away and I will not be present, proper notification will be given to the Athletic Trainer or Head coach. Bethesda students should not be in possession of or carry around medicine themselves; therefore, an appropriate adult will be in possession of medication and can disperse according to directions.

*If my son requires an Inhaler or epipen for asthma or allergies *I will provide an extra one for the medical staff during the athletic seasons,* as well as notifying the school staff.

Medications **I do not** give my son permission to have: _____

List Prescription taken on a Regular Basis and Purpose: _____

_____

_____

I have read, understand and agree to all of the above statements regarding dispersion of medications to my son during or related to athletics. Should I have any further questions I will contact the Athletic trainer.

_____

Print Student name | Student Signature | Date

_____

Print Parent/Legal Guardian | Signature | Date

SportsOne

EMERGENCY CONTACT & INSURANCE INFORMATION

Student's Name (Legal)_____, _____, _____
LAST FIRST MI

Social Security #_____-_____-_____ **D.O.B**____/____/_____ **2011-12 Grade Level:** _____

Address: _____ _____, **GA.**_____
STREET CITY ZIP

Student's Home Phone #: _____**Student's Cell Phone #:**_____

Child Lives With: ___Mother ___Father ___Both ___Other:_____

Father's Name: _____ **Home Phone #(_____)_____-_____**

Father's Employer: _____ **Work Phone # (____)_____-_____ext_____**

Father's Cell Phone # (____)_____-_____

Mother's Name:_____ **Home Phone#(_____)_____-_____**

Mother's Employer:_____ **Work Phone#(_____)_____-_____ext_____**

Mother's Cell Phone #(_____)_____-_____

Emergency Contact & Relationship (must be 21 or older): _____

Contact Home Phone # (____)_____-_____ **Contact Cell Phone # (_____) _____-_____**

Primary Physician: _____ **Office Phone # (_____)_____-_____ext_____**

Preferred Hospital_____ **EMAIL**_____

INSURANCE INFORMATION

Primary Insurance Co: _____ **Name of Policy Holder:** _____
Policy #: _____ **Group #:** _____
Insurance Co. Phone # (_____)_____-_____ext_____

Secondary Insurance Co: _____ **Name of Policy Holder:** _____
Policy #: _____ **Group #:** _____
Insurance Co. Phone # (_____)_____-_____ext_____

PLEASE BE AWARE OF THE FOLLOWING WHEN CARING FOR MY CHILD

Medical Conditions: _____

Allergies: _____

Medications & Condition: _____

PERMISSION FOR AUTHORIZATION TO TREAT IN PARENT ABSENCE

*I give permission for representatives of Bethesda Academy to authorize medical treatment for my child in my absence. This may include, but is not limited to, activation of emergency services, emergency room procedures, and injury/illness evaluation and treatment by certified athletic trainers at away competitions.

Print Parent Name:_____ **Parent Signature:**_____

PLEASE ATTACH

COPY (FRONT/BACK) OF STUDENT'S

INSURANCE CARD*

BETHESDA
ACADEMY
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ADAPTED SCHOOL FORM TO GO WITH PHYSICAL FORM

Date of exam_____

Physician Name_____

Student Name_____ Date of Birth_____

Is Child's Immunization current to age/grade requirements? YES NO

Growth & Development: Normal YES NO Underweight YES NO Overweight YES NO

Nutritional Assessment: YES NO

LAB: CBC_____ UA _____

TB: Test Date_____ Result Date_____ RESULT Positive Negative

Physician signature_____

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 _____

HE0503 9-2681/0410

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

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 _____

SportsOne
PERMISSION & MEDICAL RECORD RELEASE FORM

Student's Name: _____
Last **First** **M.I.**

ASSUMPTION OF RISK AND PERMISSION TO TREAT

I am aware playing or practicing to play/participate in any sport or sport related activity could be a dangerous activity involving **MANY RISKS OF INJURY**. I understand that the dangers and risks of playing or practicing to play/participate in sports or sport related activity include, but are not limited to: death; serious neck and spinal injuries that may result in complete or partial paralysis; brain damage; serious injury to virtually all bones, joints, ligaments, muscles, tendons, other aspects of the musculoskeletal system and vital organs; and serious impairment to other aspects of the body, general health, and well-being. I understand the dangers and risks of playing or practicing to play/participate in any sport or sport related activity may result not only in serious injury, but in a serious impairment of my (the participant's) future abilities to earn a living; to engage in other business, social, and recreational activities; and generally enjoy life. Because of the dangers of playing or practicing to play/participate in any sport or sport related activity, I recognize the importance of following the coach's, official's and medical staff's instructions regarding playing techniques, training, and other team rules, etc., and agree to obey such instructions.

As the parent / legal guardian of the above named participant, I have read the above warnings and release, and understand its terms. I hereby agree to hold the Bethesda Academy, its direct and contracted employees, agents, representatives, coaches and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever that may arise by or in connection with participation of my child in any activities related to Bethesda Academy activities. The terms hereof will serve as a release for my heirs, estate, executor, administrator, assignees, and for all members of my family. Whenever injury and/or sickness occur to the participant listed above, and the participant is under the supervision of Bethesda Academy, and the participant's parent / legal guardian is unavailable to give his/her permission for treatment, the participant and others whose signatures are attached below do hereby give permission to Memorial Health and SportsOne to authorize any emergency action necessary to ensure the safety of the child. The intention hereof being to grant authority to administer and perform all and singularly any examinations, pre-participation physical examinations, treatments, anesthetics, operations, and diagnostic procedures which may now, or during the course of this participant's care, be deemed advisable or necessary. This does not hold Memorial Health and/or the Bethesda Academy financially responsible for any medical care given. An insurance policy may be available through the school for an additional cost.

I specifically acknowledge that **Football** and **Wrestling** are **collision sports** that involve an even greater risk of injury than **contact sports: Basketball, Baseball, and Soccer** which involve greater risk of injury that **non-contact sports: Track & Field, Tennis, Cross Country, Rowing, and Golf.**

_____ ___/____/_____ _____ ___/____/____
Student's Signature Date Parent /Guardian Signature Date

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

General Disclosure:

I hereby authorize Memorial Health and/or Memorial SportsOne Medical Personnel to release information from my medical records for the purpose of payment, treatment or operations to their Business Associate Partner (which includes; the Attending School's Coaching Staff and Administrators) and any Hospital in case of an Emergency Situation. This authorization shall be valid for the duration of the 2011-2012 school year. It is subject to revocation by the patient, or the parent / guardian at any time except to the extent that action has been taken in reliance thereon. I am aware that once Memorial Health and/or Memorial SportsOne discloses this information per my instructions, the information is subject to re-disclosure and may no longer be protected by the HIPAA (Health Insurance Portability and Accountability Act) of 1996. I understand that a photocopy of this authorization shall be as valid as the original. I know that I, or my authorized representative may receive a copy of this authorization upon request.

_____ ___/___/____ _____ ___/____/_____
Student's Signature Date Parent/Guardian Signature Date