DIRECTIONS

FOR COMPLETING PHYSICAL FORMS

Dear Parent/Guardian:

In order to insure efficient and appropriate health care for your child, we must ask you to complete several forms before allowing your child to participate in interscholastic athletics or extracurricular activities.

If you should have any questions or concerns about this process, please do not hesitate to contact the Athletic Trainer at your child's high school.

Please follow the directions below for completing the attached physical forms . . .

1) Parent/Guardian ***READ, SIGN, and DATE*** "Parent/Guardian Consent Form"

2) Parent *and* athlete ***READ, SIGN, and DATE*** "Participation Waiver" (on back of #1)

3) Parent ***COMPLETE, SIGN, AND DATE*** the "Authorization for Release of Medical Information Form." Keep "HIPAA Notice of Privacy Practices" for your records.

4) Please keep the HIPAA Notice of Privacy Practices for your records.

5) ***COMPLETELY fill out the front*** of the "Pre-participation Health Screening" form, then sign and date it at the bottom. *It is* ***EXTREMELY IMPORTANT*** *that* **NO** parts of the form be left blank. Incomplete forms may not be accepted!

6) Take the forms to your doctor and have them complete the physical examination portion of the physical form (on the back of #5).

NOTE: Physical forms MUST be signed by a licensed medical doctor in South Carolina or a Certified Physician's Assistant or Family Nurse Practitioner practicing under the supervision of a licensed South Carolina MD or DO. Chiropractor signatures are NOT valid!!

Turn ***ALL*** forms to the sports medicine department at your child's high school before their first practice.

PARENT/GUARDIAN CONSENT, WAIVER, AND MEDICAL RELEASE FORM FOR ATHLETICS 2008-2009

STUDENT'S FULL NAME: ____________________________________ **DATE OF BIRTH:** _________________

SCHOOL: ____ **HOME PHONE #:** _________________

PARENT/GUARDIAN:_______________________________________ **OTHER PHONE #:** ________________

I hereby give permission for the above-named student to participate in the interscholastic athletic program beginning the date I have signed this form through June 30, 2009, and to travel on athletic trips scheduled for his/her team(s). In granting this permission, I assume full responsibility for the behavior of my child and for any and all damages to person or property caused by my child.

If it is determined that my child needs medical or dental treatment while participating in athletics, I will be financially responsible for any treatment determined to be necessary by a physician, dentist, athletic trainer, emergency medical personnel, or any other medical personnel. I give my permission for the school district's sports medicine staff to care for and provide appropriate medical treatment for my child in the event of his/her injury. I agree to be responsible for any expenses associated with sending my child home prior to the scheduled return time if an adult supervisor determines that it is necessary due to the health or behavior of my child.

Except as I have listed immediately below, I grant permission for athletic trainers licensed in South Carolina to administer the following over-the-counter, individually packaged, single-dose oral medications or their equivalents to my child consistent with District policy and as per written standing orders from a physician licensed to practice in South Carolina: Advil, Alamag, Benedryl, Throat Lozenges, Electrolyte Supplement, Calcium Supplement, Ibupro, Insta-Glucose, Motrin, Mylanta, Onset Forte, Pepto Bismol, Robitussin, Robitussin DM, Rolaids, Tums, and Tylenol (indicate below the medications from the foregoing list that you do **not** want to be administered to your child):

____

____

____.

I agree to notify the athletic trainer immediately in writing of any changes in my child's health which requires modification to my permission.

I understand that by participating in interscholastic athletics, including practices, my child is exposing himself/herself to the risk of serious injury and death. By my signature below I release and waive, and further agree to indemnify, hold harmless or reimburse the Horry County Board of Education, the individual members, employees, representatives, and agents thereof, from and against, any claim which I, any other parent or guardian, any sibling, my child, or any other person, firm, or corporation may have or claim to have, known or unknown, directly or indirectly, for any losses, damages, injuries, or adverse reactions arising out of, during, or in connection with my child's participation in athletic competition(s) and/or practice(s) and in connection with the administration of medication(s) to my child as specified above. I agree that a photocopy or facsimile of this document shall be considered the same as the original document. I HAVE READ AND UNDERSTAND THIS RELEASE AGREEMENT AND THE "INFORMATION CONCERNING PARTICIPATION IN SPORTS" PRESENTED ON THE BACK OF THIS RELEASE AGREEMENT.

____ ____________________

Signature of Parent/Guardian Date

Note: This form becomes obsolete at the end of the day June 30, 2009, but must be maintained by the school for a period consistent with the school district's records retention schedule.

Revised: 2-22-05.

Overleaf

INFORMATION CONCERNING PARTICIPATION IN SPORTS 2008-2009

By its very nature, competitive athletics puts students in situations in which **serious, catastrophic,** and **sometimes fatal accidents and illnesses** may occur. Many forms of athletic competition and practice result in violent physical contact. The use of athletic equipment may result in accidents, injury, or death. Strenuous physical exertion and numerous other exposures to the risk of injury occur while participating in interscholastic athletics.

A student and his/her parents must assess the risks involved in participation in competitive athletics and make a decision concerning whether or not the student participates in spite of the risks. No amount of instruction, precaution, or supervision will totally eliminate the risk of death, injury, or illness associated with participation in athletic activities. Just as driving an automobile involves risks, athletic participation by middle or senior high school students also may be inherently dangerous. The responsibility that parents and students have in making a choice to participate cannot be overstated. There have been accidents resulting in death, paraplegia, quadriplegia, and other very serious permanent physical impairments as a result of athletic competition and/or practice.

By granting permission for your child to participate in athletic competition and practice, you are acknowledging that you fully understand that such risks exist.

Students will be instructed in the proper techniques to be used in athletic competition and practice and in the proper utilization of equipment worn or used in practices and competitions. Students must always adhere to that instruction and utilization and must refrain from improper use or techniques.

As previously stated, no amount of instruction, precaution, and supervision will eliminate the risk of serious, catastrophic, and fatal injury or illness.

ADDITIONAL INFORMATION CONCERNING PARTICIPATION IN FOOTBALL

Football is a collision sport and injuries can, and do, occur. Safety is the major concern of the Rules Committees of the National Federation of State High School Associations, and recent rule changes have reduced the number of serious injuries.

This document does not cover all potential injury possibilities in playing football, but it is an attempt to make players and their parents aware that fundamentals and proper-fitting equipment are important to student safety and enjoyment in playing football.

By rule, the helmet is **not** to be used as a “ram.” Initial contact is not to be made with the helmet. However, it is not possible to play the game safely or correctly without making contact with the helmet when properly blocking and tackling an opponent. Therefore, technique is most important to prevention of injuries.

Tackling and blocking techniques are basically the same. The play should always be in a position of balance: knees bent, back straight, body slightly bent forward, head up, target area as near to the body as possible with the main contact being made with the shoulder.

Blocking and tackling by not putting the helmet as close to the body as possible could result in shoulder injury such as a separation or pinched nerve in the neck area. The dangers of not following the safety rules in making contact with the upper body and helmet is that improper body alignment can put the spinal column in a vulnerable position for injury.

If the head is bent downward, the cervical (neck) vertebrae are in a straight line and contact on the top of the helmet could result in a dislocation, nerve damage, paralysis, or even death. If the back is not straight, the thoracic (mid-back) and lumbar (low back) vertebrae are also vulnerable to injury with similar results.

If the knees are not bent, the chance of knee injury is greatly increased. Fundamentally, a player should be in the proper hitting position at all times during live ball play. The injury could be anything such as, but not limited to, strained muscles, ankle injuries, or serious knee injuries requiring surgical care. Blocking below the waist is permitted only in a defined area known as the “free-blocking zone” and only under the conditions specified by the football rules. Cleats have been restricted in length to further help in preventing knee injuries. A runner with the ball, however, may be tackled around the legs.

In tackling, the rules prohibit initial contact with the helmet or grabbing the face mask or edge of the helmet. Serious injuries may result from non-compliance. Initial helmet contact could result in a bruise, dislocation, fracture, head injury, or internal injury to organs such as, but not limited to, kidneys, spleen, bladder, etc. Grabbing the face mask or helmet edge could cause a serious neck injury resulting in, but not limited to, muscle strain, dislocation, fracture, nerve injury, spinal damage, paralysis, or death.

If any of the foregoing is not completely understood, please contact the school’s Athletic Director or Athletic Trainer for further information and clarification.

ACKNOWLEDGEMENT

I have read and understand the above information, and I understand the risks involved with participating in interscholastic athletic activities, including practices.

STUDENT’S SIGNATURE: ___________________________

DATE: ____________________________

PARENT’S SIGNATURE: ____________________________

DATE: ___________________________

Authorization for Release of Medical Information

Student's Name: ______________________________________ **Date of Birth:** ______ / ______ / ______
First Middle Initial Last Month Day Year

Social Security Number: __________ - __________ - __________ **Current grade in school:** ____________
(2008-2009)

I hereby authorize Horry County Schools to obtain, use, and disclose my child's protected health information ("Health Information") as defined by Federal and state law, in the manner described below. I understand that this authorization is voluntary. I also understand that if the person or entity authorized by this document to provide or receive my child's Health Information is not a health plan or health-care provider, then the disclosed Health Information may no longer be protected from further disclosure by federal or state law.

Any and all of the following Health Information may be obtained, used, or disclosed by Horry County Schools**:**

Please check the appropriate box…

☐ **All records**, including those listed below

☐ Pre-participation Physical Forms only

☐ Medical Records only

☐ Insurance Claims/Medical Billing and/or Medicaid Information only

This information may be obtained from, used by/for, or disclosed to, the following individual(s) and/or entities:

Please check the appropriate box…

☐ **All** of the individuals/entities listed below

☐ Affiliated Team Physicians only

☐ Affiliated Allied Health Care Providers such as Physical Therapists, Counselors, etc. only

☐ Family Physician only (Physician's Name(s): ____________________________________)

☐ School Athletic Insurance Policy Provider only

☐ Primary Insurance Policy Provider only

☐ Another school(s) in the event of a student transfer only.

☐ Other, please list the contact information here: Name: ____________________________________

Mailing Address: ____________________________________

____

Telephone Number: ____________________________________

I understand that my child's healthcare will not be affected if I do not sign this form.

This authorization shall expire one year from the date of my signature below.

I understand that I may revoke this authorization at any time by notifying Horry County Schools in writing. I understand that my revocation of this authorization will not affect any actions taken by Horry County Schools in reliance on this authorization prior to the time it received my revocation.

I understand that I have a right to receive a copy of this authorization.

Signature: ____________________________________ Date: ____________________

Relationship to student listed above (please check one) ☐ Parent ☐ Legal guardian

***A photocopy or facsimile of this document shall be considered the same as the original document.*

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your child's protected health information (PHI) to carry out treatment, payment for health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your child's protected health information. "Protected health information" is information about your child, including demographic information, that may identify them and that relates to their past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your child's protected health information may be used and disclosed by our sports medicine staff, team physicians, or other affiliated allied health care providers, their office staffs, and others outside of these offices that are involved in your child's care and treatment for the purpose of providing health care services to your child, to pay your child's health care bills, to support the operation of the school's athlete health care services program; affiliated team physician's practice(s); affiliated allied health care provider practice(s); and any other use required by law.

Treatment:

We will use and disclose your child's protected health information to provide, coordinate, or manage your child's health care and any related services. This includes the coordination or management of your child's health care with a third party. For example, we would disclose your child's protected health information, as necessary, to a physician to whom your child has been referred to ensure that the physician has the necessary information to diagnose and treat your child's condition.

In addition, we may disclose your child's protected health information from time-to-time to another unaffiliated physician or health care provider (e.g., a specialist or laboratory) who, at the request of our affiliated team physician(s) or other affiliated allied health care providers, becomes involved in the care of your child by providing assistance with your child's health care diagnosis or treatment.

Payment:

Your child's protected health information will be used, as needed, by affiliated team physicians and other affiliated allied health care providers to obtain payment for your child's health care services. For example, in order to obtain approval for payment of services from your insurance company your child's protected health information may be disclosed to that company or other insurance companies being billed for said services.

Healthcare Operations:

We may use or disclose, as needed, your child's protected health information in order to support the operation of the school's athlete health care services program, the business activities of our affiliated team physician's practice, and the practices of other allied health care providers. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, a sign in sheet in the athletic training room or affiliated team physician's office or affiliated allied health care provider's office may be used where your child (or their parent/guardian) may be asked to sign their name and indicate the reason for their visit or the name of the physician or allied health care provider they are scheduled to see. We may also call your child by name while visiting the athletic training room or while in the waiting room at a physician or allied health care provider's office. We may use or disclose your child's protected health information, as necessary, to contact you to remind you of your child's medical appointment(s) or to provide you with other related information related to your child's care and treatment.

We may use or disclose your child's protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Abuse and Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Overleaf

Communication Barriers:

We may use and disclose your child's protected health information if we, our affiliated team physician(s), or affiliated allied health care providers attempt to obtain consent from you but are unable to do so due to substantial communication barriers and we, our affiliated team physician(s), or affiliated allied health care providers determine, using profession judgment, that you intend to consent to use and disclosure of your child's protected health information under the circumstances.

Other Permitted and Required Uses and Disclosures:

Will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that the school's sports medicine staff, affiliated team physician(s), or other affiliated allied health care provider(s) and/or their practices have taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights:

The following is a statement of you and your child's rights with respect to your child's protected health information.

You have the right to inspect and copy your child's protected health information. You have the right to request a restriction of your child's protected health care information. This means you may ask us not to use or disclose any part of your child's protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your child's care or for notification purposes as described in the Notice of Privacy. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our sports medicine staff, affiliated team physician(s), and other affiliated allied health care providers are not required to agree to a restriction that you may request. If the sports medicine staff, affiliated team physician(s), and other affiliated allied health care providers believe it is in your child's best interest to permit use and disclosure of your child's protected health information, your PHI will not be restricted. You then have the right to use another health care professional.

You have the right to request and receive confidential communication from us by alternative means or at an alternative location. You have a right to obtain a paper copy of this notice from us.

You may have the right to have our sports medicine staff, affiliated team physician(s), and other affiliated allied health care providers amend your child's protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your child's PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

To file a complaint concerning our privacy practices, you may submit a written complaint to your child's building level Principal, the Horry County Schools Office of Policy and Legal Issues, PO Box 260005, Conway, SC 29528-6005, 843-488-6700, or you may submit a complaint to the Secretary of Health and Human Services, The U.S. Department of Health and Human Services, 200 Independence Avenue, S.W. Washington, D.C.20201, 202-619-0257.

We will not retaliate against you or your child for filing a complaint.

This notice was published and became effective on or before **April 1, 2005**.

HORRY COUNTY SCHOOLS
PREPARTICIPATION HEALTH SCREENING FOR ATHLETICS/EXTRACURRICULAR ACTIVITIES

Personal Information (PLEASE PRINT) ***ALL ITEMS IN BOLD PRINT MUST BE COMPLETED!!**

Name ____ **Sex** {circle} **M F** **Grade** {circle} **7 8 9 10 11 12**
FIRST MIDDLE LAST (2008-2009)

Date of Birth {Month/Day/Year} _________/_________/_________ **Social Security Number of Student** _________ - _________ - _________

Mailing Address ______________________________________ **City** ____________________ **Zip Code** __________

Parent/Guardian ______________________________ **Home Phone** ________________ **Work Phone** ______________

Person to Notify in an Emergency _________________________ **Phone** ________________ **Alternate** ______________

Family Doctor ____________________________________ **Phone** ________________ **Alternate** ______________

Is this student covered by private health care/medical insurance and/or Medicaid? ____ **Yes** ____ **No** **Medicaid #:** ________________

Name of private healthcare/medical insurance provider: ____

Policy Holder's Name: ____________________________________ **Social Security # :** _________ - _________ - _________

Group Name: ________________________________ **Group #:** ____________ **Policy #:** ______________________

Sports you plan to play {√ all that apply} ____ **Football** ____ **Basketball** ____ **Baseball** ____**Softball** ____ **Volleyball** ____ **Wrestling** ____ **Soccer** ____ **Track** ____ **Swimming** ____ **Weight Lifting** ____**Tennis** ____**Golf** ____ **Cross Country** ____ **Cheerleading** ____ **Dance Team** ____**NJROTC**

Medical History **(Answer ALL questions by checking the YES or NO boxes. Explain ALL "Yes" answers in the space below!!)**

	GENERAL MEDICAL HISTORY:	YES	NO
1.	HAVE YOU HAD ANY MEDICAL PROBLEM OR PHYSICAL INJURY SINCE YOUR LAST PHYSICAL EXAM?	ف	ف
2.	Do you have asthma?...	ف	ف
3.	Do you have diabetes? ……………………………………………….	ف	ف
4.	Do you have high blood pressure? ………………………………..	ف	ف
5.	Do you have seizures?..	ف	ف
6.	Do you have sickle cell trait? ………………………………………..	ف	ف
7.	Have you have any other major medical problem? ……………..	ف	ف
8.	Have you ever been hospitalized or had surgery? ……………..	ف	ف
9.	Do you cough, wheeze, or have trouble breathing when exercising? ……………………………………………………………..	ف	ف
10.	Do you use an inhaler? ……………………………………………….	ف	ف
11.	Do you have a single organ (testicle or kidney)? ………………..	ف	ف
12.	Are you currently taking any medicines or do you take any medicines on a regular basis (prescription or over-the-counter)? ……………………………………………………………….	ف	ف
13.	Have you ever taken any supplements or vitamins to help with weight loss, weight gain, or to improve performance? …………	ف	ف
14.	Do you have any allergies (seasonal, insects, food, or medicines)? ……………………………………………………………..	ف	ف
15.	Have you ever had a rash or hives develop during or after exercise? ………………………………………………………………..	ف	ف
16.	Do you have any skin problems other than acne? ………………	ف	ف
17.	Have you ever had a head injury, been knocked out, lost your memory, had your "bell rung", or a concussion? ……………….	ف	ف
18.	Have you ever had numbness or tingling in your arms, hands, legs, or feet? …………………………………………………………….	ف	ف
19.	Have you ever had a "stinger", "burner", or pinched nerve? …	ف	ف
20.	Have you ever become ill from exercising in the heat? ………..	ف	ف
21.	Have you had mononucleosis or any significant illness in the last 60 days? ……………………………………………………………	ف	ف
22.	Do you have trouble with your eyes/vision/wear glasses or contacts? ………………………………………………………………..	ف	ف
23.	Do you have trouble with your hearing/wear hearing aids? …...	ف	ف
24.	Do you want to weigh more or less than you do now? …………	ف	ف
25.	Do you lose weight regularly to meet weight requirements for your sport or other reasons? ………………………………………..	ف	ف
26.	Do you feel stressed out, overly tired, or depressed? …………	ف	ف
27.	Are there any other issues you would like to discuss with the doctor?...	ف	ف

	FEMALES ONLY:	YES	NO
28.	Are your periods regular (every month)?....................................	ف	ف
29.	Are your periods heavy?...	ف	ف
30.	When was your first period? Month ________ Year ________		
31.	When was your last period? Month ________ Year ________		
	CARDIAC HISTORY:	**YES**	**NO**
1.	Have you ever passed out during or after exercise? ……………	ف	ف
2.	Have you ever been dizzy during or after exercise? ……………	ف	ف
3.	Have you ever had chest pain or chest pressure during or after exercise? ………………………………………………………….	ف	ف
4.	Do you tire easily or more quickly than your friends during exercise? ………………………………………………………………..	ف	ف
5.	Have you ever had racing of your heart or skipped heartbeats? ……………………………………………………………..	ف	ف
6.	Have you ever been told you had a heart murmur? ……………..	ف	ف
7.	Have you ever been told you had an enlarged heart? ………….	ف	ف
8.	Has any member of your family:		
	- died of heart problems or sudden death before age 50?..........	ف	ف
	- been told they had a serious heart problem before age 50?....	ف	ف
	- been told they had Marfan's Syndrome?...................................	ف	ف
9.	Has a physician ever denied or restricted your participation in sports?..	ف	ف
	ORTHOPAEDIC HISTORY:		
1.	Have you ever broken or fractured any bones?..........................	ف	ف
2.	Have you ever dislocated or partially dislocated any joint?.......	ف	ف
3.	Have you had any problems related to your:		
	- neck, spine, or back?..	ف	ف
	- shoulders?...	ف	ف
	- elbows?..	ف	ف
	-wrists, hands, or fingers?...	ف	ف
	- hips?...	ف	ف
	- knees?..	ف	ف
	- ankles, feet, or toes?..	ف	ف
	- other?..	ف	ف

Please explain YES answers from above in this space: ____

____

____

____

Signature of parent/guardian: ____ **Date signed:** ______________

***A photocopy or facsimile of this document shall be considered the same as the original document.*

Horry County Schools
Preparticipation Health Screening Examination

Date: ____________________

Physical Examination

Name: ____ **Age:** _____ **Date of Birth:** _____/_____/_____

Height __________ Weight __________ BP _______/_______ Pulse _______ Respiration _______

Vision R 20/_____ L 20/ _____ Corrected (CIRCLE): Yes No If yes, with? (CIRCLE) Glasses Contacts

COMPLETE	LIMITED		NORMAL	ABNORMAL FINDINGS	INITIALS
		CARDIPULMONARY			
		PULSES			
		HEART			
		LUNGS			
		SKIN			
		ABDOMINAL			
		GENITALIA			
	MUSCULOSKELETAL		**NORMAL**	**ABNORMAL FINDINGS**	**INITIALS**
	NECK				
	SHOULDERS				
	ELBOWS				
	WRISTS				
	HANDS				
	BACK/SPINE				
	HIP/PELVIS				
	KNEES				
	ANKLES				
	FEET				
	DENTAL EXAM		**NORMAL**	**ABNORMAL FINDINGS**	**INITIALS**
	GUMS AND TONGUE				
	TEETH				
	TMJ JOINT				

Clearance (check one): ☐ CLEARED ☐ Cleared *after* completing evaluation/treatment for: ____________________

☐ **NOT CLEARED** for sport/activity (list) ________________________________

☐ **NOT CLEARED FOR ANY SPORTS PARTICIPATION** due to: ____________________

Other recommendations: ____

Name of Examining Physician: ______________________________ Phone Number: ______________

Signature of Examining Physician: ____________________________ Date: ____________________