

1093 Flat Rock Rd.  
Stockbridge, GA 30281  
770-389-1591  
www.northhenryacademy.com



Head of School – Pastor Stan Jordan  
Principal - Mrs. Cynthia Temple

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**By God's power, NHA is changing the world ~ one child at a time.**

Dear NHA Family,

Thank you for your interest in sports at NHA! The Athletic Department of North Henry Academy exists to help change lives one student at a time by instilling discipline, hard-work, integrity, fair-play and the ability to glorify God in all things (1 Corinth. 10:31) through sports. To do this we have implemented diverse programs with qualified coaches to compete at the highest level of interscholastic athletics. As a Georgia Association of Private and Parochial Schools (GAPPS) member school we demonstrate that we value professional development, cooperation, and accountability to help us achieve these goals.

We have chosen our current sports programs (Volleyball, Cross Country, Basketball and Intramurals) for the upcoming school year to provide diverse athletics year-round. Additional programs, such as Cheerleading, Softball, Baseball, Track and Field, Soccer and Flag-Football, will be added in the future as we are able to do so while maintaining high standards of excellence.

As the Athletic Director at North Henry Academy, I'm here to serve the families of NHA by helping to ensure that this mission is fulfilled, and you and your student have the best and most productive experience possible. We truly want to partner with parents and are looking to increase our parent volunteer involvement. We need parents to work the concession stand, clock, and the scorebook. Your volunteer time to help during athletic events can go toward your 15 service hours that are required by the school. If you have any interest in helping or have any questions about Athletics at NHA, do not hesitate to let me know.

Our coaching staff and I are excited for what the future holds in all our sports. God bless and Go Lions!

Sincerely,

Leigh Sullivan, Athletic Director

[leighsullivan@northhenryacademy.com](mailto:leighsullivan@northhenryacademy.com)

Sean Walker, Basketball Coach

[seanwalker@northhenryacademy.com](mailto:seanwalker@northhenryacademy.com)

# North Henry Academy Athletic/Extra-Curricular Info & Consent Form

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle I. \_\_\_\_\_

Preferred Name/Nickname: \_\_\_\_\_

Birthday \_\_\_\_\_ (include year) Home Phone \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Relationship: \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Relationship: \_\_\_\_\_

Parent or Guardian Work Phone: \_\_\_\_\_

Parent or Guardian E-mail: \_\_\_\_\_

Student Resides With \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency Phone \_\_\_\_\_

The Undersigned Consent to the following:

1. Compete in Interscholastic Athletics at North Henry Academy **except** for those CROSSED OUT below:  

Basketball	Cross-Country	Volleyball
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2. Student may accompany any school team of which student is a member on the bus for out of town trips of activities.
3. Agrees to pay \$150 for each sport your student participates in (\$200 for AES Players).

**WARNING: BY ITS NATURE, PARTICIPATION IN INTER-SCHOLASTIC SPORTS INCLUDE A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CATASTROPHIC INJURY INCLUDING PARALYSIS AND DEATH. PARTICIPANTS AND PARENTS HAVE A RESPONSIBILITY TO HELP REDUCE THE CHANCE OF INJURY.PARTICIPANTS MUST OBEY ALL SAFETY RULES, FOLLOW A PROPER CONDITIONING PROGRAM, AND REPORT ALL PHYSICAL PROBLEMS TO COACHES OR ADMINISTRATION. PARENTS MUST REPORT ANY PROBLEMS OR MEDICAL CONDITIONS TO COACHES OR ADMINISTRATION. BY COMPLETING AND SIGNING THIS FORM, YOU ACKNOWLEDGE THE INHERENT RISK. YOU ALSO GIVE CONSENT FOR NAMED STUDENT TO PARTICIPATE AND RIDE THE BUS UNTIL THIS FORM IS REVOKED IN WRITING.**

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Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**North Henry Academy  
Athletic Department**

**Parent Code of Ethics**

It is the duty of all concerned with the North Henry Academy athletic program to exemplify the highest ideals of sportsmanship, ethical conduct, and fair play. Parents are to realize that an athletic contest is a game, the purpose of which is to promote the physical, social, and spiritual development of the individual athletes. It is expected that all parents will respect and abide by the guidelines for the behavior described in the following code of ethics.

1. To embrace the highest ideals of sportsmanship, ethical conduct, and fair play.
2. To show courtesy and respect to all visiting teams, officials, teammates, parents and coaches at all times.
3. To thoroughly understand and uphold the rules of the game.
4. To refrain from using language that degrades, baits, and intimidates others.
5. To treat the coach with respect and to discourage other fans, students, and parents from undercutting the coach's authority.
6. To refrain from entering the field or court, standing on the sidelines, or yelling instructions to the coach and/or players during games and practices.
7. To refrain from taunting or booing officials and/or coaches and athletes during the game.
8. To respect the officials and their authority during and after the games.
9. To refrain from confronting the officials and/or coaches at the game field or on the school premises immediately before and/or after the game.

Failure to follow the above guidelines will include the following disciplinary actions:

1. Verbal warning
2. Written warning
3. Parental game suspension
4. Parental season suspension

The school reserves the right to follow any level of disciplinary actions depending on the severity of the infraction.

*By signing this code of ethics, you are stating that you have read and understand the above items. You are also stating that you are aware of the consequences for failure to follow the above guidelines. This document must be signed BEFORE student-athletes can participate in any athletic contest.*

Parent's Name \_\_\_\_\_ Date \_\_\_\_\_

Parent's Signature \_\_\_\_\_

Student-Athlete's Name \_\_\_\_\_ Grade \_\_\_\_\_

# Medical Information Form

Full Legal Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Social Security Number: (Required for treatment at most hospitals) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ Grade: \_\_\_\_\_

List all Allergies or medical conditions that would impact treatment:

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Medications taken on a regular basis: \_\_\_\_\_

Name of Parents or Legal Guardian: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

List Two Other Emergency Contacts

1) Name & Phone Number: \_\_\_\_\_

2) Name & Phone Number: \_\_\_\_\_

Name of Primary Insurance Policy Owner: \_\_\_\_\_

Insurance Company & Address: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Secondary Insurance Policy Owner: \_\_\_\_\_

Insurance Company & Address: \_\_\_\_\_

Policy Number: \_\_\_\_\_

I hereby give permission for authorized personal of **(School Name)** \_\_\_\_\_ to grant permission for medical treatment for my child, **(Child's Name)** \_\_\_\_\_, if I am not readily available, and I authorize the physician and such other health care provider selected by **(School Name)** \_\_\_\_\_ to render such emergency medical treatment as deemed necessary under the circumstances.

Parent or Legal Guardian: \_\_\_\_\_

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**North Henry Academy  
Athletic Department**

**Uniform/Equipment Agreement Form**

Athletes selected to participate on a sports team will be issued a uniform by the school. Uniforms should be taken care of and washed after each use according to the directions and specifications on the label.

Please take note of the following items concerning uniforms and equipment.

1. Each individual player is responsible for his/her issued equipment/uniform.
2. Aside from normal wear and tear, all equipment and uniforms should be returned at the conclusion of the season in the condition in which they were issued.
3. School issued uniforms are NOT to be worn at non-NHA athletic events.
4. Any damage to an item needs to be reported to the head coach immediately. Damage caused outside of a game and/or practice will need to be paid by the student-athlete.
5. Any replacements needing to be made to uniform/equipment partial or full will be the cost of the item + shipping.
6. Grade reports and/or transcripts will be held until all accounts are settled in the event that a uniform in whole or part is not returned.

*By signing this form, I acknowledge that I have read the athletic uniform/equipment agreement and consent to abide by its procedures and regulations.*

Parent's Name \_\_\_\_\_ Date \_\_\_\_\_

Parent's Signature \_\_\_\_\_

Student-Athlete's Name \_\_\_\_\_ Date \_\_\_\_\_

Student-Athlete's Signature \_\_\_\_\_

# Georgia Association of Private & Parochial Schools

Fayetteville, GA 30214

[www.gappschools.com](http://www.gappschools.com)

contact@gappschools.com

(678) 679-7123



## Concussion Information and Acknowledgement Form

Parent and Student:

It is important that parents and students are educated about concussions. All concussions are serious, and concussions can occur in any sport.

1. Definition of Concussion: A brain injury that interferes with the normal brain function.
2. Cause of Concussions: A bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth.
3. Signs and Symptoms of Concussions:

<b>Headache</b> <b>Nausea</b> <b>Vomiting</b> <b>Dizziness</b> <b>Confused</b> <b>Sluggish</b> <b>Fatigue</b> <b>Blurry Vision</b> <b>Memory Loss</b> <b>Appears Dazed</b>	<b>Slurred Speech</b>  <b>Moves Clumsily</b> <b>Balance Problems</b> <b>Forgets Instruction</b> <b>Numbness/Tingling</b> <b>Loses Consciousness</b> <b>Concentration Problems</b> <b>Slowed Thought Process</b> <b>Difficulty Thinking Clearly</b>	<b>Answers Questions Slowly</b> <b>Sensitivity to Light or Noise</b> <b>Unsure of Game, Score or Opponent</b> <b>Shows Mood, Personality or Behavior Changes</b> <b>Cannot Recall Events Prior To or After Injury</b>
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4. In accordance with Georgia Law, the following must occur if an individual exhibits signs, symptoms or behaviors of a concussion:
  - a. The individual shall be immediately removed from practice or competition.
  - b. The individual suspected of having a concussion shall be seen by an appropriate health care professional before the individual can return to athletic participation.
  - c. The individual shall not return to practice or competition the same day the concussion or suspected concussion occurred.
  - d. If no concussion has occurred, the individual can return immediately to practice or competition
  - e. If a concussion has occurred, the individual cannot return to participation in practice or competition until medically cleared by an appropriate health care professional.
  - f. An individual could never return to participation if the individual still has any symptoms of a concussion.
  - g. After clearance has been issued, the individual's actual return to participation in practice and competition should follow a gradual procedure suggested by the National Federation of High Schools and directed by the appropriate health care provider clearing the athlete for activity.
  - h. An appropriate health care profession may include licensed doctor or another licensed individual under the supervision of a licensed doctor such as a nurse practitioner, physician assistant, or certified athletic trainer who has received training in concussion evaluation and management.
5. The following information can be found online and is recommended for parents and students to read concerning concussions:
  - a. NFHS Suggested Guidelines for Management of Concussion in Sports.
  - b. NFHS, A Parent's Guide to Concussions in Sports
6. Parent and student should sign the form below. The school and parent should maintain a copy of this form.

I have read this form and I understand the facts presented in it.

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Parent/Guardian Printed Name

Student Printed Name

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Parent/Guardian Signature

Student Signature

Date

**Georgia Association of  
Private & Parochial Schools**

Fayetteville, GA 30214  
[www.gappschools.com](http://www.gappschools.com)  
contact@gappschools.com  
(678) 679-7123



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## Application to Play-Up

School name: \_\_\_\_\_

Athlete name: \_\_\_\_\_

Current Grade Level: \_\_\_\_\_

Sport: \_\_\_\_\_

In my opinion, \_\_\_\_\_, is mentally and physically capable of  
(Student Name)

participating on a **varsity/middle school** level even though he/she is under the required grade level for the sport being played, according to the Rules Manual of Georgia Association of Private & Parochial Schools.

Signed by:

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School Head Administrator

Date

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School Athletic Director

Date

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Athlete's Parent

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: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> 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

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

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		
	<b>Yes</b>	<b>No</b>
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**

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

	<b>Yes</b>	<b>No</b>
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**

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**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

- 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?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____ ( _____ / _____ )	Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> 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 <sup>a</sup> • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) <sup>b</sup>		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic <sup>c</sup>		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

<sup>a</sup>Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.

<sup>c</sup>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 \_\_\_\_\_

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