# DOUGLAS COUNTY SCHOOL SYSTEM ~ RELEASE / EMERGENCY MEDICAL FORM

## PLEASE READ CAREFULLY

## EMERGENCY MEDICAL AUTHORIZATION

**Student:** _____ **Home Phone:** _____ **Address:** _____

**Mother's Name:** _____ **Bus. Phone:** _____ **Father's Name:** _____ **Bus. Phone:** _____

**Family Physician:** _____ **Phone:** _____ **Dentist:** _____ **Phone:** _____

**Insurance Company:** _____ **Policy #** _____ **Group #** _____

**WHOM CAN WE CONTACT IF NO PARENT/GUARDIAN CAN BE REACHED TO ASSUME RESPONSIBILITY FOR THIS STUDENT?**

Name: _____ Phone: _____

**Activities Agreement**

To insure the proper atmosphere for interscholastic competition, the participant and his/her parents or guardians must understand and cooperate in helping establish that atmosphere by adhering to all school rules and regulations. When a violation of school rules occurs proper steps will be taken. A participant may be suspended from participating in interscholastic activities or from a team for violating any of the following standards: (1) falsification of physician's signature, parent or guardian's signature, any information pertaining to school enrollment, school records, or interscholastic activity forms; (2) use of, possession of, or distribution of alcohol or tobacco; misuse of non-prescription drugs, or of controlled substances; (3) theft or destruction to property of any school or individual; (4) repeated acts of unsportsmanlike conduct; (5) failure to follow rules as set for individual activities by coaches.

A student must have his/her parent's or guardian's signed permission to participate. All athletic participation requires a physical examination with the doctor's permission to participate. The participant is required to abide by the rules and regulations of the State Board of Education, the Douglas County Board of Education, and the Georgia High School Association.

**Informed Consent**

We realize that such activities involve the potential for injury to our son or daughter which is inherent in all activities. We acknowledge that even with the best coaching, use of the most advanced protective equipment, and strict observance of rules, injuries to our son/daughter are still a possibility. We recognize that on rare occasions these injuries to our son/daughter can be so severe as to result in total disability, paralysis or even death.

**Drug Testing Consent (High School Only)**

We understand that submission to testing for the presence of drugs and alcohol is a condition of participation in privileged activities in the Douglas County School System. We further understand that refusal to take the test, failure to report for the test, or if the test establishes a violation of the drug testing policy, our son/daughter will be subject to consequences as set forth by the drug testing policy.

**General Release**

It is anticipated that my son/daughter, while a participant in interscholastic activities in the Douglas County School System, will travel to many activities off campus. Transportation for my child to these off campus activities may be school buses, private vehicles, or alternate transportation operated by employees or agents of the School System. In consideration of their performing this valuable service for me and my child, I hereby release and discharge any and all claims and causes of action of any kind or nature which may arise out of my child's travel while at school both for myself and my minor child. It is the express intent of this release to forever hold the Douglas County School System, its agents and employees, harmless for any injuries which may occur to my child as a result of travel while he or she is in the custody of the School System.

**Insurance Waiver**

I fully understand that the Douglas County School System does not provide any insurance and it is my responsibility to provide insurance coverage for my son/daughter. The Douglas County School System will not assume liability for injuries incurred by my son/daughter during participation in or practice of any interscholastic activity.

A parent/guardian may elect to enroll the participant in a supplemental school insurance program which is authorized by the Douglas County School System. If you choose to purchase coverage through this plan, contact the school principal or head coach for additional information.

**Authorization:**

In case of an emergency or accident during any school activity involving my child, which in the opinion of school authorities present requires immediate medical or surgical attention, I authorize the school to take such emergency actions as may be deemed necessary, including the transportation of the student to a hospital or medical center and authorizing medical treatment. I hereby grant permission, also to said physician to treat said condition unless I am present and request otherwise. I assume the responsibility for any medical expenses incurred during this emergency. The coach, school, or the Douglas County School System will not be held responsible for any medical expenses.

**Permission to Participate:**

I have carefully read and understand each of the above section and will comply with these policies or statement.
Permission is granted to my son/daughter to practice and complete in interscholastic activities.

| Parent/ Guardian Signature | | Student Signature | |
|---|---|---|---|
| _____ | Date: ___/___/___ (Mo. Day Year) | _____ | Date: ___/___/___ (Mo. Day Year) |

***Revised 2019***

## DOUGLAS COUNTY SCHOOL SYSTEM CONDUCT AGREEMENT FOR ATHLETIC PARTICIPATION

Participation in athletic activities is a ***privilege*** in schools and ***not a property right***. It is to be understood by all students, parents/guardians, and coaches that the top priority is academic progress. Everyone involved in these activities will make every effort not to interfere with that ultimate goal. The purpose of this Athlete Conduct Agreement is to establish minimum standards of behavior. Therefore, ***coaches and/or administrators may establish rules and consequences that are more severe than those stated below.*** Team rules must be approved by the administration of each school. As a precondition to participate in DCSS Middle School governed athletics, the student and his/her parent/guardian agree that the following rules will apply:

### VIOLATIONS and CONSEQUENCES
**(Violations are cumulative throughout a student's 6th – 8th grade educational career)**

| | VIOLATION | CONSEQUENCES |
|---|---|---|
| **A.** | **Violation of school rules resulting in In-School Suspension (ISS) or Out-of-School Suspension (OSS) during the season.** | The student may resume participation when:<br>1. The student is released from ISS; or<br>2. The student returns to school on the next school day upon completion of OSS. |
| **B.** | **Violation of school rules resulting in assignment to alternative school** | Dismissed from athletics while attending alternative school. |
| **C.** | **Student has been criminally charged with a misdemeanor, regardless of location or time, so long as such charges are pending or conviction is had. *** | **1st Offense** –School administration and the coach will meet with the student and parent/guardian and discuss consequences determined by the school, which may include suspension from athletic participation.<br>**2nd Offense** – Suspension from athletic participation beginning with the date of the charges. Track, Football, Football Cheerleading, Soccer one game. Basketball, Basketball Cheerleading , Softball two games.<br>**3rd Offense** – Suspension of 1 calendar year in middle school from athletic participation beginning with the date of the charges.<br>**4th Offense** – Permanent suspension from athletic participation |
| **D.** | **Student found to have been in possession of, or criminally charged with, the use/possession of alcohol, illegal drugs, unauthorized use/possession of prescription drugs or other behavior altering substances.*** | **1st Offense** – Suspension from athletic beginning with the date student is found to be in possession or charged. Track, Football, Football Cheerleading, Soccer one game. Basketball, Basketball Cheerleading, Softball two games.<br>**2nd Offense** – Suspension of 1 calendar year in middle school. from athletic participation beginning with the date student is found to be in possession or charged.<br>**3rd Offense** – Permanent suspension from athletic participation. |
| **E.** | **Student has unresolved felony charges or felony conviction.*** | **1st Offense** – Suspension for 1 calendar year in middle school. from athletic participation beginning with the date of arrest.<br>**2nd Offense** – Permanent suspension from athletic participation. |
| **F.** | **A student who commits any of the following offenses may be suspended or permanently dismissed from a team: missing practice unless excused, truancy or skipping classes, acting in an unsportsmanlike manner when representing the school, any act at school or away from school which results in any discipline by school administration, or any act at school or away from school which in the opinion of the Principal reflects in a negative manner on the school or athletic program.** | |

* If out of season, consequences will begin on the next competition date with which the student is affiliated.

*NOTE: Parent/guardian must report any criminal charge or arrest of the student and related details to school athletic director or coach within 1 week of the charge or arrest, even during school breaks. Failure to do so may result in the student being suspended from athletic participation for (1) calendar year in middle school.*

Student's Signature:_____ Date:_____ Parent/Guardian Signature:_____ Date:_____

Revised: 07/15/19

## ■ PREPARTICIPATION PHYSICAL EVALUATION

# HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

*Over the last 2 weeks, how often have you been bothered by any of the following problems? (**check box next to appropriate number**)*

| | Not at all | Several days | Over half the days | Nearly every day |
|---|---|---|---|---|
| Feeling nervous, anxious, or on edge | ☐0 | ☐1 | ☐2 | ☐3 |
| Not being able to stop or control worrying | ☐0 | ☐1 | ☐2 | ☐3 |
| Little interest or pleasure in doing things | ☐0 | ☐1 | ☐2 | ☐3 |
| Feeling down, depressed, or hopeless | ☐0 | ☐1 | ☐2 | ☐3 |

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

| GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.) | Yes | No |
|---|---|---|
| 1. Do you have any concerns that you would like to discuss with your provider? | ☐ | ☐ |
| 2. Has a provider ever denied or restricted your participation in sports for any reason? | ☐ | ☐ |
| 3. Do you have any ongoing medical issues or recent illness? | ☐ | ☐ |
| **HEART HEALTH QUESTIONS ABOUT YOU** | **Yes** | **No** |
| 4. Have you ever passed out or nearly passed out during or after exercise? | ☐ | ☐ |
| 5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | ☐ | ☐ |
| 6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? | ☐ | ☐ |
| 7. Has a doctor ever told you that you have any heart problems? | ☐ | ☐ |
| 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. | ☐ | ☐ |

| HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*) | Yes | No |
|---|---|---|
| 9. Do you get light-headed or feel shorter of breath than your friends during exercise? | ☐ | ☐ |
| 10. Have you ever had a seizure? | ☐ | ☐ |
| **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** | **Yes** | **No** |
| 11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)? | ☐ | ☐ |
| 12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? | ☐ | ☐ |
| 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? | ☐ | ☐ |

| BONE AND JOINT QUESTIONS | Yes | No |
|---|---|---|
| 14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? | ☐ | ☐ |
| 15. Do you have a bone, muscle, ligament, or joint injury that bothers you? | ☐ | ☐ |
| **MEDICAL QUESTIONS** | **Yes** | **No** |
| 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? | ☐ | ☐ |
| 17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | ☐ | ☐ |
| 18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area? | ☐ | ☐ |
| 19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)? | ☐ | ☐ |
| 20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? | ☐ | ☐ |
| 21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? | ☐ | ☐ |
| 22. Have you ever become ill while exercising in the heat? | ☐ | ☐ |
| 23. Do you or does someone in your family have sickle cell trait or disease? | ☐ | ☐ |
| 24. Have you ever had or do you have any problems with your eyes or vision? | ☐ | ☐ |

| MEDICAL QUESTIONS (*CONTINUED*) | Yes | No |
|---|---|---|
| 25. Do you worry about your weight? | ☐ | ☐ |
| 26. Are you trying to or has anyone recommended that you gain or lose weight? | ☐ | ☐ |
| 27. Are you on a special diet or do you avoid certain types of foods or food groups? | ☐ | ☐ |
| 28. Have you ever had an eating disorder? | ☐ | ☐ |
| **FEMALES ONLY** | **Yes** | **No** |
| 29. Have you ever had a menstrual period? | ☐ | ☐ |
| 30. How old were you when you had your first menstrual period? | | |
| 31. When was your most recent menstrual period? | | |
| 32. How many periods have you had in the past 12 months? | | |

**Explain "Yes" answers here.**

**I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.**

Signature of athlete: _____

Signature of parent or 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, e-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-enhancing 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 (Q4–Q13 of History Form).

| EXAMINATION | | |
|---|---|---|
| Height: Weight: | | |
| BP: / ( / ) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N | | |
| **MEDICAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) | ☐ | |
| Eyes, ears, nose, and throat<br>• Pupils equal<br>• Hearing | ☐ | |
| Lymph nodes | ☐ | |
| Heart[a]<br>• Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) | ☐ | |
| Lungs | ☐ | |
| Abdomen | ☐ | |
| Skin<br>• Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis | ☐ | |
| Neurological | ☐ | |
| **MUSCULOSKELETAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Neck | ☐ | |
| Back | ☐ | |
| Shoulder and arm | ☐ | |
| Elbow and forearm | ☐ | |
| Wrist, hand, and fingers | ☐ | |
| Hip and thigh | ☐ | |
| Knee | ☐ | |
| Leg and ankle | ☐ | |
| Foot and toes | ☐ | |
| Functional<br>• Double-leg squat test, single-leg squat test, and box drop or step drop test | ☐ | |

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

## ■ PREPARTICIPATION PHYSICAL EVALUATION

# ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: _____ Date of birth: _____

| | |
|---|---|
| 1. Type of disability: | |
| 2. Date of disability: | |
| 3. Classification (if available): | |
| 4. Cause of disability (birth, disease, injury, or other): | |
| 5. List the sports you are playing: | |

| | Yes | No |
|---|---|---|
| 6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities? | | |
| 7. Do you use any special brace or assistive device for sports? | | |
| 8. Do you have any rashes, pressure sores, or 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 as having 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 whether you have ever had any of the following conditions:**

| | Yes | No |
|---|---|---|
| Atlantoaxial instability | | |
| Radiographic (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 questions on this form are complete and correct.**

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

## ■ PREPARTICIPATION PHYSICAL EVALUATION

# MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

### SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

# Georgia High School Association
# Student/Parent Concussion Awareness Form

SCHOOL: _____

**DANGERS OF CONCUSSION**

Concussions at all levels of sports have received a great deal of attention and a state law has been passed to address this issue. Adolescent athletes are particularly vulnerable to the effects of concussion. Once considered little more than a minor "ding" to the head, it is now understood that a concussion has the potential to result in death, or changes in brain function (either short-term or long-term). A concussion is a brain injury that results in a temporary disruption of normal brain function. A concussion occurs when the brain is violently rocked back and forth or twisted inside the skull as a result of a blow to the head or body. Continued participation in any sport following a concussion can lead to worsening concussion symptoms, as well as increased risk for further injury to the brain, and even death.

Player and parental education in this area is crucial – that is the reason for this document. Refer to it regularly. This form must be signed by a parent or guardian of each student who wishes to participate in GHSA athletics. One copy needs to be returned to the school, and one retained at home.

**COMMON SIGNS AND SYMPTOMS OF CONCUSSION**

- Headache, dizziness, poor balance, moves clumsily, reduced energy level/tiredness
- Nausea or vomiting
- Blurred vision, sensitivity to light and sounds
- Fogginess of memory, difficulty concentrating, slowed thought processes, confused about surroundings or game assignments
- Unexplained changes in behavior and personality
- Loss of consciousness (NOTE: This does not occur in all concussion episodes.)

**BY-LAW 2.68: GHSA CONCUSSION POLICY:** In accordance with Georgia law and national playing rules published by the National Federation of State High School Associations, any athlete who exhibits signs, symptoms, or behaviors consistent with a concussion shall be immediately removed from the practice or contest and shall not return to play until an appropriate health care professional has determined that no concussion has occurred. (NOTE: An appropriate health care professional may include licensed physician (MD/DO) or another licensed individual under the supervision of a licensed physician, such as a nurse practitioner, physician assistant, or certified athletic trainer who has received training in concussion evaluation and management.

a) No athlete is allowed to return to a game or a practice on the same day that a concussion (a) has been diagnosed, OR (b) cannot be ruled out.

b) Any athlete diagnosed with a concussion shall be cleared medically by an appropriate health care professional prior to resuming participation in any future practice or contest. The formulation of a gradual return to play protocol shall be a part of the medical clearance.

***By signing this concussion form, I give _____High School permission to transfer this concussion form to the other sports that my child may play. I am aware of the dangers of concussion and this signed concussion form will represent myself and my child during the 2019-2020 school year. This form will be stored with the athletic physical form and other accompanying forms required by the _____School System.***

***I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.***

| | | |
|---|---|---|
| _____ | _____ | _____ |
| ***Student Name (Printed)*** | ***Student Name (Signed)*** | ***Date*** |
| _____ | _____ | _____ |
| ***Parent Name (Printed)*** | ***Parent Name (Signed)*** | ***Date*** |

(Revised: 2/19)

# Georgia High School Association
# Student/Parent Sudden Cardiac Arrest Awareness Form

SCHOOL: _____

1: Learn the Early Warning Signs

If you or your child has had one or more of these signs, see your primary care physician:

- Fainting suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks or ringing phones
- Unusual chest pain or shortness of breath during exercise
- Family members who had sudden, unexplained and unexpected death before age 50
- Family members who have been diagnosed with a condition that can cause sudden cardiac death, such as hypertrophic cardiomyopathy (HCM) or Long QT syndrome
- A seizure suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks or ringing phones

2: Learn to Recognize Sudden Cardiac Arrest

If you see someone collapse, assume he has experienced sudden cardiac arrest and respond quickly. This victim will be unresponsive, gasping or not breathing normally, and may have some jerking (Seizure like activity). Send for help and start CPR. You cannot hurt him.

3: Learn Hands-Only CPR

Effective CPR saves lives by circulating blood to the brain and other vital organs until rescue teams arrive. It is one of the most important life skills you can learn – and it's easier than ever.

- Call 911 (or ask bystanders to call 911 and get an AED)
- Push hard and fast in the center of the chest. Kneel at the victim's side, place your hands on the lower half of the breastbone, one on top of the other, elbows straight and locked. Push down 2 inches, then up 2 inches, at a rate of 100 times/minute, to the beat of the song "Stayin' Alive."
- If an Automated External Defibrillator (AED) is available, open it and follow the voice prompts. It will lead you step-by-step through the process, and will never shock a victim that does not need a shock.

***By signing this sudden cardiac arrest form, I give _____ High School permission to transfer this sudden cardiac arrest form to the other sports that my child may play. I am aware of the dangers of sudden cardiac arrest and this signed sudden cardiac arrest form will represent myself and my child during the 2019-2020 school year. This form will be stored with the athletic physical form and other accompanying forms required by the _____ School System.***

***I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.***

| | | |
|---|---|---|
| _____ | _____ | _____ |
| ***Student Name (Printed)*** | ***Student Name (Signed)*** | ***Date*** |
| _____ | _____ | _____ |
| ***Parent Name (Printed)*** | ***Parent Name (Signed)*** | ***Date*** |

(Revised: 5/19)

# DOUGLAS COUNTY SCHOOL SYSTEM

## Consent to Participation – Student Drug Testing

I understand that submission to testing for the presence of drugs and alcohol is a condition of participation in privileged activities in the Douglas County School System. I further understand that if I refuse to take the test, fail to report for the test, or if the test establishes a violation of the drug testing policy, I will be subject to consequences as set forth by the drug testing policy.

By signing and dating this form, I consent to take an initial drug test, if required, and be randomly tested throughout the school year. The initial drug test, when required, is to be completed prior to the start of the privileged activity. The random testing will be done monthly throughout the school year. The selection process for random drug testing will be performed by the contracting body with the participating students being notified on the day they are to report for testing.

**I hereby consent to the administration of drug tests and to the conditions listed in this consent and the accompanying general prohibitions and procedures as outlined in Policy JCDAB-R/JCDAC-R,JCDAB-R(1) of the Douglas County School System Policy Manual.**

**I understand that unless my parent or guardian contacts the Drug Testing Administrator after the first year, and makes a formal request to remove my name and student ID number from the testing pool, my name will automatically be re-entered into the testing pool each year.**

**Participating Student's Name:**

_____

**Date:** _____ **Signature:** _____

**Parent/Guardian's Name:**

_____

**Date:** _____ **Signature:** _____

# DCSS Athletics 2020-2021

# Infectious Disease Plan Template for COVID-19

**Purpose**

With the recent occurrence of COVID -19 and concerns for re- opening of high school athletics, the following guidelines are being implemented. These guidelines are for the protection of all, athletes, coaches, athletic training and other medical personnel, and affiliated support staff in accordance with current Governor's Office, Center for Disease Control and Prevention (CDC), and Georgia High School Association (GHSA) guidelines/policies. These guidelines will be flexible and subject to change as time, information, and research is updated. It has been established by health care authorities and leaders to have a process for screening and educating athletes, parents, and staff to self-monitor and report pertinent changes as they are encountered.

**Process for screening and testing**

1. Every athlete, coach, or staff member will be screened prior to participating in any workout using the attached (school generated) COVD 19 screening form and all screenings will be documented.
2. If an athlete presents with symptoms or has had a recent direct exposure, the athlete will be removed from activity and will not be allowed to return until:
    i. Proof of a negative COVID 19 test
    ii. 14 day quarantine and symptom free
3. If at any time an athlete/coach/staff tests positive for COVID 19, all other members of that workout group will be notified and will not be allowed to return until:
    i. Proof of a negative COVID 19 test
    ii. 14 day quarantine and symptom free
4. If screenings are performed by a coach, the screening form will be completed and emailed to the Head Athletic Trainer and/or Athletic Director, as soon as completed.
5. Self-monitoring is to be instituted continuously. All athletes, coaches, and staff are to be educated as to the importance of and signs to be monitored via this process.
6. Reported self-monitoring positives are to follow the above process for screening and testing as indicated and recorded in the athlete's record.

**Athletic Training Clinic Procedures**

1. One athlete per athletic trainer will be allowed in the clinic at a time.
2. At this time the clinic will be utilized for major rehab and acute injury care only.
3. At home rehabs will be utilized when possible.

**Cleaning Procedures**

**Athletic Training Clinic**

1. Every table will be cleaned at the beginning of each day and after each patient.
2. Athletic Training staff will wash hands or use hand sanitizer before and after contact with every patient.
3. All reusable equipment to be cleaned after use by each athlete.
4. Personal Protection Equipment (PPE) to be provided and worn / used as indicated.
5. All disposable goods and PPE to be disposed of properly.

**Weight Room**

1. The weight room will be fogged with disinfectant prior to workouts each day and immediately following each workout session
2. Any equipment used by an athlete during a workout will be cleaned prior to use by any other athlete.

**Other Equipment**

1. Any equipment used during workouts will be cleaned prior to workouts beginning and immediately following each workout.
2. Any equipment used by an athlete during a workout will be cleaned prior to use by any other athlete.

**Athlete Recommendations**

1. At this time, due to safety concerns, no water will be provided during workouts. Athletes are required to bring their own water. **We recommend a minimum of 1 gallon.** Athletes will not be allowed to participate in workouts if they do not bring their own water.
2. It is highly encouraged to maintain appropriate distancing between athletes, during activities, rest breaks, etc.
3. All athletes are encouraged to change clothes and immediately shower as soon as possible after practices and activities. All clothing worn during workouts should be washed immediately following each workout.
4. A bathroom will be designated for use at each workout location on campus and only one athlete will be allowed to use the bathroom at a time.