PIKE COUNTY MIDDLE SCHOOL
ZEBULON, GA

I/We, the undersigned parent(s) and/or guardian(s) of hereby grant permission for my child,

_____, _____, to participate in (Sport/Activity) _____
(PRINT Last Name) (PRINT First Name)

for the 20___- 20___ school year.

** I/We understand that if an injury occurs to my child during practice/game/performance that I/We are responsible for filing an accident report with the staff supervisor.

** I/We understand that I/We are responsible for filing school insurance within 90 days of the injury.

** I/We have been made aware of procedures that will be in place to provide safeguards to staff and students related to COVID-19. I/We confirm that we are comfortable with the articulated procedures and the risks associated with my child's participation in this activity.

_____, _____
(PRINT Parent/Guardian Last Name) (PRINT Parent/Guardian First Name)

_____
Parent/Guardian Signature

_____
Date

Pike County Schools

Infectious Disease Plan for COVID-19

Purpose

With the recent occurrence of COVID -19 and concerns for re- opening of high school activities, the following guidelines are being implemented. These guidelines are for the protection of all students, staff, 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 student / athlete, coach, or staff member will be screened prior to participating in any workout / activity using the attached (school generated) COVD 19 screening form and all screenings will be documented.
2. If any student / athlete presents symptoms or has had a recent direct exposure, the student / 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 student/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.

Pike County Schools

Infectious Disease Plan for COVID-19

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

Student / Athlete Recommendations

1. At this time, due to safety concerns, no water will be provided during workouts. Students / 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 students / 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 activities / workouts should be washed immediately.
4. A bathroom will be designated for use at each location on campus and only one athlete will be allowed to use the bathroom at a time.

Community Acquired Methicillin Resistant Staphylococcus Aureus (CA-MRSA)

According to the Centers for Disease Control and Prevention, participants in competitive sports are at risk for skin infections because of physical contact, skin damage, and sharing of equipment. Humid, crowded conditions such as those found in locker rooms and gyms provide a good place for Staphylococcus Aureus (Staph) to grow. The following will provide the student and parent with practical information:

➢ Staph is commonly carried in nasal passages, under fingernails, or on the skin without any medical problems. It can enter the body from a cut, insect bite, or surgical incision. Normally a minor infection occurs. However, if a person has a weakened immune system from an illness, the infection could become more serious.

➢ Prevention involves players, coaches, parents, and the school. The following practices are recommended to parents of students when the conditions warrant:

- The student should wash hands thoroughly with soap and water during the day. Waterless hand cleanser can be used.
- The student should practice good hygiene to include showering/bathing with soap and water after all practices and competitions. Previously worn protective clothing can be hot and cause chafing which results in broken skin. Skin trauma from turf or mat burns are other risk factors.
- Use liquid soap in showers instead of sharing bar soaps; sharing can spread bacteria to other family members. Shower as soon as possible after practice/working out/competitions.
- It is suggested to wash towels after each use and avoid sharing bed liners, razors, and other personal items.
- The student should not store or wear previously worn wet clothing. Wet or damp clothing/equipment is a breeding ground for bacteria and fungus.
- The student will cover all open wounds. If a wound cannot be covered, there is a possibility that the student will need to be excluded from practice/ workout/ competition until the wound heals.
- Students should report skin lesions to the parent as well as the coach. Parents and coaches will check a lesion that is potentially infected.
- The student and parents should understand the importance of seeking medical attention at the first sign of infection. Early signs are redness and swelling of the affected area, pain, drainage (pus) around the area of an insect bite, cut or abrasion.
- If medication is prescribed by a physician, the student should take the entire amount of medication in the prescribed amount of time. Follow school rules regarding medicine on campus.
- The student should avoid getting into a hot tub or whirlpool until all wounds are healed.

Information obtained from the Centers for Disease Control and Prevention and State Epidemiologist Cristina Pasa. For more information visit the Centers for Disease Control and Prevention website.

2.67 **Practice Policy for Heat and Humidity:**

(a) Schools must follow the statewide policy for conducting practices and voluntary conditioning workouts (this policy is year-round, including during the summer) in all sports during times of extremely high heat and/or humidity that will be signed by each head coach at the beginning of each season and distributed to all players and their parents or guardians. The policy shall follow modified guidelines of the American College of Sports Medicine in regard to:
  (1) The scheduling of practices at various heat/humidity levels.
  (2) The ratio of workout time to time allotted for rest and hydration at various heat/humidity levels.
  (3) The heat/humidity levels that will result in practice being terminated.

(b) A scientifically-approved instrument that measures the Wet Bulb Globe Temperature must be utilized at each practice to ensure that the written policy is being followed properly. WBGT readings should be taken every hour, beginning 30 minutes before the beginning of practice.

WBGT	ACTIVITY GUIDELINES AND REST BREAK GUIDELINES
Under 82.0	Normal Activities - Provide at least three separate rest breaks each hour with a minimum duration of 3 minutes each during the workout.
82.0 - 86.9	Use discretion for intense or prolonged exercise; watch at-risk players carefully. Provide at least three separate rest breaks each hour with a minimum duration of 4 minutes each.
87.0 - 89.9	Maximum practice time is 2 hours. <u>For Football</u>: players are restricted to helmet, shoulder pads, and shorts during practice, and all protective equipment must be removed during conditioning activities. If the WBGT rises to this level during practice, players may continue to work out wearing football pants without changing to shorts. <u>For All Sports</u>: Provide at least four separate rest breaks each hour with a minimum duration of 4 minutes each.
90.0 - 92.0	Maximum practice time is 1 hour. <u>For Football</u>: no protective equipment may be worn during practice, and there may be no conditioning activities. <u>For All Sports</u>: There must be 20 minutes of rest breaks distributed throughout the hour of practice.
Over 92.0	No outdoor workouts. Delay practice until a cooler WBGT level is reached.

(c) Practices are defined as: the period of time that a participant engages in a coach-supervised, school-approved sport or conditioning-related activity. Practices are timed from the time the players report to the practice or workout area until players leave that area. If a practice is interrupted for a weather-related reason, the "clock" on that practice will stop and will begin again when the practice resumes.

(d) Conditioning activities include such things as weight training, wind-sprints, timed runs for distance, etc., and may be a part of the practice time or included in "voluntary workouts."

(e) A walk-through is not a part of the practice time regulation, and may last no longer than one hour. This activity may not include conditioning activities or contact drills. No protective equipment may be worn during a walk-through, and no full-speed drills may be held.

(f) Rest breaks may not be combined with any other type of activity and players must be given unlimited access to hydration. These breaks must be held in a "cool zone" where players are out of direct sunlight.

PIKE COUNTY SCHOOL SYSTEM
AUTHORIZATION TO CARRY STUDENT TO HOSPITAL

I hereby authorize _____ to take my child to the hospital emergency room for treatment. I understand that I am legally responsible for any financial obligations incurred in the emergency treatment of my child.

_____ _____
Name of Student Name of Parent

_____ _____
Social Security Number Date

AUTHORIZATION FOR THIRD PARTY TO CONSENT TO TREATMENT OF MINOR LACKING CAPACITY TO CONSENT

I/We, the undersigned, parent(s)/person having legal custody/legal guardianship of _____, a minor, do hereby authorize _____ as agent(s) for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon duly licensed, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

These authorizations shall remain effective until _____, 20____ unless sooner revoked in writing delivered to said agent(s).

_____ _____
Date Parent/Legal Guardian

_____ _____
Student Name Student Social Security Number

_____ _____
Student's Birthdate Parents(s)/Guardian Name

_____
Permanent Address (Street, PO Box, City, Zip)

_____ _____
Area Code+Home Phone Area Code+Work Phone (Parent)

_____ _____
Emergency Contact Area Code+Emergency Phone

_____ _____
Insurance Carrier Policy Number

Georgia High School Association
Student/Parent Concussion Awareness Form

SCHOOL: PIKE COUNTY

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: PIKE COUNTY

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)

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 • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)	☐	
Eyes, ears, nose, and throat • Pupils equal • Hearing	☐	
Lymph nodes	☐	
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)	☐	
Lungs	☐	
Abdomen	☐	
Skin • 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 • 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

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: _____

_____

_____