Dear Parent/Guardian:

Attached is documentation required in order for your child to participate in middle school and high school athletics in Kershaw County School District. Please read this information completely, and feel free to contact the athletics department at your child's school should you have any questions or concerns. All forms must be completed prior to participation in any athletics related activity.

Please fill out the following and provide necessary documentation:

Last Name: _____ First Name: _____ Middle Name: _____
Address: _____
Parent/Guardian: _____ Contact No: _____
Parent/Guardian: _____ Contact No: _____
In Case of Emergency: _____ Contact No: _____

_____Copy of Birth Certificate

_____Athletic Participation Fee

_____ Completed SCHSL Physical Form *History completed thoroughly and accurately, athlete marked as "cleared" and physical signed by a MD, DO, PA or NP, dated after April 1 of the previous school year.

_____Participation Form

In consideration of the student named above being permitted to voluntarily participate in the sport, activity, club, and program, I for myself, my child and our heirs, personal representatives, and /or assigns, do hereby release, agree to hold harmless, and waive any claim against, discharge for liability, and promise not to sue the Kershaw County School District, its officers, employees, volunteers, and/or agents for liability from all and all claims including the negligence of the Kershaw County School District, its officers, employees, and agents, with respect to any and all personal injury, accidents, illness, or property loss or property damage arising from, but not limited to the above-named student's participation in the activity.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Kershaw County School District
Participation Form

Permission to Participate, Assumption the Risk, And Secondary Insurance Acknowledgement

As the parent or legal guardian of the above named student-athlete, I/we give my permission for his/her participation in athletic events and physical evaluation (PPE) by a physician, physician's assistant, or nurse practitioner for that participation. I/We understand that the PPE is simply a screening evaluation and not a substitute for regular healthcare. I/We know that the risk of injury/illness to my child comes with participation in sports and during travel to/from activities. I/We have had the opportunity to understand the risk of injury during participation in sports through meetings, written information, or by some other means and give my/our permission to participate in interscholastic athletics. Kershaw County School District carries athletic accident insurance on all students participating in extracurricular activities. This accident insurance benefits provided by the school system will pay only toward those covered expenses in excess of expenses recoverable from other insurance. There are limitations under this insurance coverage. It will not always pay all of the charges incurred for every accident. In the event of injury, while participating as a part of a SCHSL sanctioned sports team representing KCSD, the athlete should seek the attention of their school's Sports Medicine staff as soon as possible. A staff member will fill out the top portion of the insurance claim form. The parent/guardian should complete the remainder of the form, follow the directions, and mail the completed form to the insurance company. Medical care must be initiated within 60 days, and forms must be submitted directly to the Insurance Company by the PARENT within 90 days of the date of injury to be eligible for coverage. KCSD or its schools cannot be held responsible for the financial or other costs associated with injuries sustained while participating in athletics.

Concussion Information

I have received and understood information in some means regarding concussions and brain injury, which has informed me of the nature and risk of concussion and brain injury, including the risks associated with continuing to participate in physical activity after a concussion or brain injury. I understand that any symptom(s) of concussion should be reported to my child's coach immediately, and that my child should not participate in any physical activity, driving of a motor vehicle, or strenuous mental activity until evaluated for concussion and cleared by an appropriate healthcare provider (physician, athletic trainer, physician assistant, or nurse practitioner). If diagnosed with a concussion, I understand that my child must be symptom free, cleared by a licensed physician, and complete a gradual return to play protocol supervised by a qualified medical professional prior to resuming physical activity in accordance with South Carolina State Law. It is highly recommended that the clearing physician be specifically trained in the management of sports related concussion

Release of Medical Information

I/We grant permission to Nurses, Certified Athletic Trainers, Coaches, Physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to all necessary medical information. I/We grant the school's Sports Medicine staff access to medical information concerning my son/ daughter by a physician or their staff. Likewise, the school's Sports Medicine staff may release medical information to Physician's offices, Coaches, Nurses, Administrators, and school/district Faculty/Staff.

Consent for Medical Treatment

I/We give consent for treatment deemed necessary for a condition arising during participation of events, including medical or surgical treatment recommended by a medical doctor. I grant permission to Certified Athletic Trainers and Coaches, as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. Furthermore, I give permission for my child to receive medical care, without explicit parental notification, from the school's Sports Medicine staff and/or Team Physicians if he/she becomes injured while participating in an event.

By signing below, I attest that the provided information is correct, and that I understand and agree to the statements above regarding Permission to Participate, Assumption of Risk, Secondary Insurance Acknowledgement, Release of Medical Information, Concussion Acknowledgement, and Consent for Medical Treatment. I/We commit to reporting ALL injuries and illnesses to the Sports Medicine staff, especially any symptoms of a possible concussion. Please contact the school's Athletic Director/ Sports Medicine Staff prior to scheduling any appointments for injuries sustained as a result of participation in athletics. I/We also understand that the Sports Medicine staff requires written documentation and clearance from any medical care received prior to returning to activities, even if it is not the result of participation in athletics. When the Sports Medicine staff determines that advanced medical care is required, the athlete must provide written clearance from an appropriate provider, prior to returning to participation. I/we will not condone participation in any activities against medical advice or until the athlete is cleared by an appropriate medical provider (as determined by the school's Sports Medicine staff).

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ 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: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

HE0503 9-2681/0410

Preparticipation Physical Evaluation
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete had been cleared for participation, the physician may rescind the clearance until the problem is resolve 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