

Parents,

This letter is meant to explain to you each form in this PHS Athletic Packet. **Please make sure you have checked both sides of each paper and filled out the appropriate information on each sheet.** Included in this packet is the Emergency Medical Authorization form that will allow the coaches to transport your child to the hospital and receive treatment in the case of an emergency. You will be contacted before transport is made. As a result of that, we also have included the PHS Insurance Information Form. **All PHS athletes are required to have health insurance in order to participate.** An “Athletic Insurance” plan is available to football players. The school insurance plan is available to athletes participating in PHS sports other than football. Please notify the coach or school nurse if you are interested in purchasing the available insurance.

Due to the new GHSA Policy regarding heat and humidity, PHS has developed a Fluid Replacement Policy that the athlete themselves must fill out. The Physical Evaluation Form has been included and must be completed by a doctor. There is also a form concerning concussions. Please read over this with your child. The last form is the Permission to Treat/HIPAA Privacy Act form that would allow the athletic trainer to treat your child, as well as discuss any injuries/illnesses they have with those you deem appropriate.

Again, this packet was created to ensure the safety of your child while participating in PHS Athletics. **All of these forms are required for participation and must be filled out correctly before your child will be allowed to participate in any sport at PHS.** If you have any questions, please do not hesitate to contact me at Pickens High School (706) 253-1800. Thank you for your support of Pickens High School Athletics...and GO DRAGONS!!!

Sincerely,

Kyle D. Rasco, EdS., ATC  
Athletic Director  
Certified Athletic Trainer, PHS

**CHECK LIST:**

- \_\_\_\_\_ Emergency Medical Authorization
- \_\_\_\_\_ Insurance Information
- \_\_\_\_\_ Fluid Replacement Policy
- \_\_\_\_\_ HIPPA Document
- \_\_\_\_\_ Concussion form
- \_\_\_\_\_ Physical Evaluation Form

**\*REQUIRED FOR PARTICIPATION\***

Dear Parents:

As of August 1<sup>st</sup>, 2005, Pickens High School has had a full-time Certified Athletic Trainer (ATC) on staff. This position was created to ensure the safety and healthcare of your children, as well as our student athletes. This person will be responsible for many different domains of care including: prevention, emergency management, rehabilitation, taping & bracing, injury assessment, therapeutic treatment, nutrition and medical referrals. In order to become a certified athletic trainer, one must not only finish an accredited curriculum, but also pass the National Athletic Trainer's Association Board of Certification Examination.

Before your child participates in rehabilitation, treatment or is seen by a physician, you will be contacted for permission. This applies to any athlete under the age of 18. However, according to federal law (HIPAA & FERPA-Privacy Act) any treatment done on any person 18 or older does not require a guardian's permission and is a violation of that law if the athlete's Personal Health Information is discussed without the athlete's permission. For this reason, all athletes are required to sign an authorization form authorizing the certified athletic trainer to discuss the athlete's Personal Health Information with parents, coaches and physicians. If the athlete does not sign the Authorization Form, they will not be allowed to participate in PHS Athletics.

Again, this position was designed to offer your child the safest environment and care to participate in athletics. The ATC will be available, if not present, at all practices and games with every sport held at Pickens High School. By signing this form, you as the legal guardian are acknowledging that you have read the above information and are giving permission for your child to be medically treated in case of an emergency situation. If there are any medical conditions or medical history that you feel the ATC needs to be made aware of, please contact them immediately.

Student's Full Name: \_\_\_\_\_

Legal Representative's Name: \_\_\_\_\_

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

- *If 18 or older, your signature is required.*

*(continue to next page)*

**\*REQUIRED FOR PARTICIPATION\***

**Pickens High School Sports Medicine  
Student Athlete Authorization**

**Purpose:** This form is used to authorize Pickens High School Sports Medicine to use or disclose your Personal Health Information (PHI) to the individual(s) or class(es) of persons you designate and for the Sports Medicine Department to disclose your PHI for the purposes stated on the completed form.

**Section A:** *Individual authorizing use and/or disclosure –Complete information.*

This authorization is good for one year from the date it is signed.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

**Section B:** *The Use and/or Disclosure Being Authorized*

The PHI to be disclosed will be injury and/or illness information that directly affects your participation in high school athletics. It is important for the student to understand that this authorization is all or none. If you give permission to disclose PHI, you give permission to disclose any PHI to any of the parties indicated below within the discretion of the Certified Athletic Trainer.

I hereby authorize Pickens High School Sports Medicine to disclose personal health information about me to the following entities: *initial next to each as they apply*

\_\_\_\_\_ Head/ Assistant Coach

\_\_\_\_\_ Parent/ Legal Guardian

\_\_\_\_\_ Medical Providers

\_\_\_\_\_ Professional/ Collegiate Teams

\_\_\_\_\_ Insurance Companies

I understand that it is necessary for head coaches, assistant coaches, & medical providers to have access to my PHI if I am to participate in high school athletics. Accordingly, I acknowledge that if I do not give permission for my PHI to be shared with these persons, I will not be allowed to participate in high school athletics at Pickens High School.

**Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice to the ATC. I also understand that by revocation of this authorization, it may affect my ability to participate in high school athletics at PHS.

**Media Disclosure:** You are not required to give PHI to the media as a condition for participation in athletics at PHS. PHI disclosed to the media will be done on a case by case and will require written permission by the athlete per injury/ illness.

**Section C:** Individual's signature

I, \_\_\_\_\_(please print) have had full opportunity to read and consider the contents of this authorization, and I understand that by signing this form, I am confirming my authorization of the use and/or disclosure of my PHI as described on this form.

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

Parent/Guardian signature (if under 18 yrs of age) \_\_\_\_\_

**\*REQUIRED FOR PARTICIPATION\***

**Pickens High School Athletics:**  
**Emergency Medical Authorization**

\_\_\_\_\_  
**Student's Name**

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**Grade**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**Zip**

\_\_\_\_\_  
**Emergency Telephone #**

\_\_\_\_\_  
**Parent's/Guardian's Name**

\_\_\_\_\_  
**Alternate Person**

\_\_\_\_\_  
**Alternate's Telephone #**

*Purpose: To enable parents to authorize emergency treatment for children who become ill or injured under school authority when parents cannot be reached*

**Part I or II Must be Completed**

**Part I-TO GRANT CONSENT**

In the event reasonable attempts to contact me(**parent's name**)\_\_\_\_\_ at  
(**Phone #**)\_\_\_\_\_ or (**alternate person's name**)\_\_\_\_\_  
at (**alternate person's #**)\_\_\_\_\_ have been unsuccessful, I hereby give  
my consent to any member of the coaching staff of any treatment deemed necessary. I also grant  
consent to the coaches to transfer my child to Piedmont Mountainside Hospital or any hospital  
reasonably accessible. This authorization does not cover major surgery unless the medical  
opinions or 2 other licensed physicians concurring in the necessity for such surgery are obtained  
before surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken and any  
physical impairment to which a physician should be alerted:\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

(Continued on opposite side)

*(Do not complete if you completed Part I)*

**Part II-REFUSAL TO CONSENT**

I do not give my consent for emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the coaches to take no action. If I cannot be contacted, I wish the coaches to take no action or to: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_

**\*REQUIRED FOR PARTICIPATION\***

# **PICKENS HIGH SCHOOL**

## **Students Application for Participation in Interscholastic Athletics and Verification of Insurance**

This form is to be completed by the parent/guardian and student prior to the first practice session. This form is to accompany this athlete to all practices and contests. Parent(s) acknowledge that they have read and understand all the information provided when they sign this form. Failure to submit this form will delay the eligibility of the student athlete to join the team. Participation in supervised interscholastic athletics includes a risk of injury which may range in severity from minor to long-term. It is possible to minimize the risk, but not to eliminate it entirely. Participants can and have the responsibility to help reduce the risk of injury. Participants must obey all safety rules, report all physical problems to their coaches and the school's athletic trainer and inspect their equipment daily. By signing this permission form, you acknowledge that you have read and understand this warning. Parents or students who do not wish to accept the risks described in this warning should not sign the permission form.

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

Student Name: \_\_\_\_\_ Male/Female (circle one)

Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Emergency Telephone: \_\_\_\_\_

Parent/Guardian Names: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Grade Level: (circle one) 9 10 11 12

Student Signature: \_\_\_\_\_

I (We) hereby give our consent for \_\_\_\_\_ to represent his/her school in interscholastic athletics. I (we) understand the possible risks involved with participation in interscholastic athletics. If I (we) cannot be reached in the event of a medical emergency, I (we) do give consent for the school to obtain emergency transportation to the physician or hospital of its choice, and such medical care as is reasonably necessary for the welfare of the student if he/she is injured in the course of participation in interscholastic activities.

Signature of Parent/Guardian: \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date \_\_\_\_\_

(Continue to other side)

**\*REQUIRED FOR PARTICIPATION\***

**Important: All student athletes are required to have medical/health insurance in order to participate in the Pickens County Schools Interscholastic Athletics Programs.** Students must be enrolled in the medical/health insurance coverage that has been approved by the Pickens County School System or enrolled in substitute medical/health insurance through a bona fide insurance provider. Parent/guardian must verify substitute insurance coverage below.

**Verification of Insurance Coverage**

I (We) have waived the medical/health insurance coverage that has been approved by the Pickens County School System and offered to my child

\_\_\_\_\_.

The medical/health insurance that I am using for my child for the current school year is provided by (Name of Insurance Company)\_\_\_\_\_

and the insurance policy number is\_\_\_\_\_.

The insurance policy is in effect from \_\_\_\_\_to \_\_\_\_\_.

I(We) certify that the insurance information provided is valid and current. I(We) acknowledge that it is My(Our) responsibility to notify the PHS Athletic Department of any change in My(Our) child's insurance coverage. Failure on My(Our) part to notify the PHS Athletic Department of any change in coverage or the falsification of insurance coverage will result in My(Our) full responsibility should my child be injured or require medical treatment while participating in PHS Athletics and I(We) hereby release PHS from any responsibility.

**ALL PARENTS/GUARDIANS MUST SIGN BELOW AND DATE:**

Signature of Parent/Guardian:\_\_\_\_\_Date:\_\_\_\_\_

Signature of Parent/Guardian:\_\_\_\_\_Date:\_\_\_\_\_

## Pickens High School Hydration & Fluid Replacement Policy

Heat illness is used to define several types of afflictions suffered when an individual experiences a rising body temperature and dehydration. Listed below are the different forms of heat illness defined by the NATA (National Athletic Trainers Association).

<b>Type</b>	<b>Symptoms</b>	<b>Treatment</b>
Heat Cramps	<ul style="list-style-type: none"> <li>• Muscle spasms due to imbalance in water and electrolytes. Usually affects the legs and abdominals</li> </ul>	<ul style="list-style-type: none"> <li>• Rest in a cool place</li> <li>• Drink plenty of fluids</li> <li>• Proper stretching</li> <li>• Application of ice if needed</li> </ul>
Heat Exhaustion	<ul style="list-style-type: none"> <li>• Normal to high temperature</li> <li>• Heavy Sweating</li> <li>• Skin is flushed or cool and pale</li> <li>• Headaches, dizziness</li> <li>• Rapid pulse, nausea and weakness</li> <li>• Physical collapse may occur</li> <li>• Can occur without prior symptoms and may be a precursor to Heat Stroke</li> </ul>	<ul style="list-style-type: none"> <li>• Get to a cool place immediately out of the heat</li> <li>• Drink plenty of fluids</li> <li>• Remove excess clothing</li> <li>• May immerse entire body in cool water</li> </ul>
Heat Stroke	<ul style="list-style-type: none"> <li>• Body's cooling system shuts down</li> <li>• Increased core temperature of 104° or higher</li> <li>• Sweating stops</li> <li>• Shallow breath and rapid pulse</li> <li>• Disorientation and loss of consciousness possible</li> <li>• Possible irregular heart rhythm and cardiac arrest</li> </ul>	<ul style="list-style-type: none"> <li>• Call 911 Immediately</li> <li>• Cool bath with ice packs near large arteries (neck, armpits and groin)</li> <li>• Replenish fluids by drinking or intravenously if needed</li> </ul>

Cold water will be readily available during rest periods, which will be increased depending on the WBT. If a student requests water during an unscheduled time, they will be granted permission to hydrate themselves immediately.

Hydration and fluid replacement is a daily process. Students should hydrate themselves before, during and after practice and games. Meals should include an appropriate amount of fluid intake in addition to a healthy diet. Each student will be personally responsible for weighing themselves in and out, monitoring their water loss after each practice or event. The recommended intake for water loss during practice is listed in the next chart.



**\*REQUIRED FOR PARTICIPATION\***

## **FLUID REPLACEMENT**

<b><i>Weight Loss During Workouts</i></b>	<b><i>Fluid Amount Needed to Rehydrate</i></b>
<b>2 Pounds</b>	<b>32 oz. (4 cups or 1 sports drink bottle)</b>
<b>4 Pounds</b>	<b>64 oz. (8 cups or 2 sports drink bottle)</b>
<b>6 Pounds</b>	<b>96 oz. (12 cups or 3 sports drink bottle)</b>
<b>8 Pounds</b>	<b>128 oz. (16 cups or 4 sports drink bottle)</b>

### **Guidelines for Hydration During Exercise**

- 1. Drink 16-24oz. of fluid 1 to 1 ½ hours before the workout or competition.*
- 2. Drink 4-8oz. of water or sports drink during every 20 minutes of exercise.*
- 3. Drink before you feel thirsty. When you feel thirsty, you have already lost needed fluids.*
- 4. Fluids that are appropriate for hydration are: water, sports drinks, some juices.  
Fluids that can cause dehydration are: sodas, tea, coffee, energy drinks*

**Please sign the appropriate area showing that you have read and understand Pickens High School's Hydration and Fluid Replacement Policy as required by the Georgia High School Association.**

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**Kyle D. Rasco, EdS., ATC  
Pickens High School  
Athletic Director  
Certified Athletic Trainer**

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**Student's Signature (date)**

**\*REQUIRED FOR PARTICIPATION\***

## **PHS STUDENT/PARENT CONCUSSION AWARENESS FORM**

### **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.

### **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.
- c) It is mandatory that every coach in each GHSA sport participate in a free, online course on concussion management prepared by the NFHS and available at [www.nfhslearn.com](http://www.nfhslearn.com) at least every two years -beginning with the 2013-2014 school year.
- d) Each school will be responsible for monitoring the participation of its coaches in the concussion management course, and shall keep a record of those who participate.

**\*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.\***

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

SIGNED: \_\_\_\_\_

(Student)/DATE

\_\_\_\_\_  
(Parent or Guardian)/DATE

