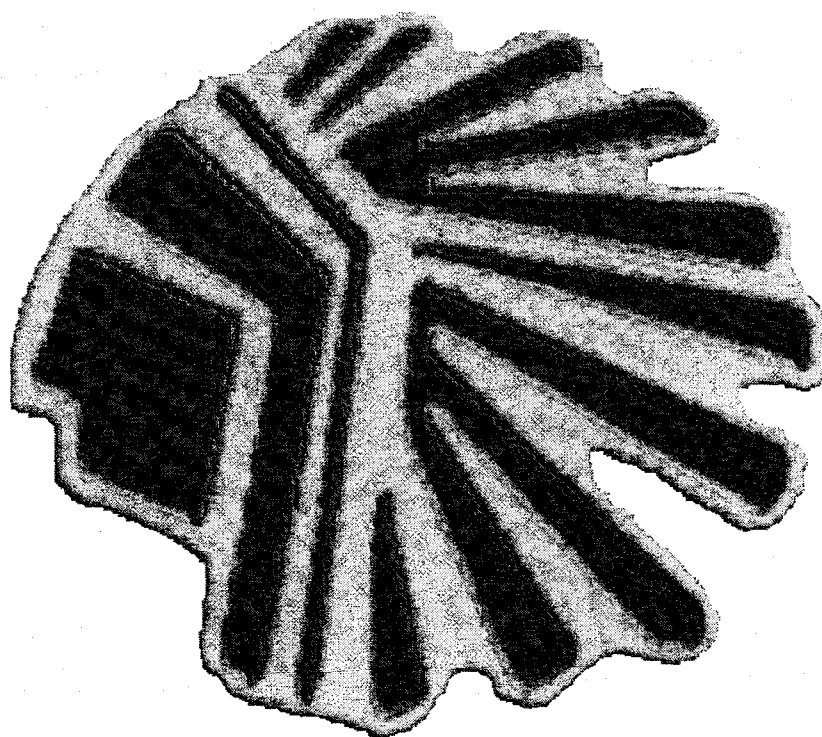


# 2008 ECHS Marching Indians Forms Packet



*All forms inside this packet must be returned to the  
band room by May 15, 2008*

**Physical Examination** (in this packet- you **must** use this GHSA form)

All students must have a sports physical on file with ECHS before starting band or color guard practice *No one will be allowed to participate without a physical on file.* If you are a middle school student and you have a form on file at your current school, please make a note on the form and we will request a copy.



# Information Sheet

## Student Information:

Name \_\_\_\_\_ Grade for the upcoming school year \_\_\_\_\_ (2008-2009)

Age \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_

I am interested in:     Playing an instrument             Being a member of Color Guard  
(circle one)

What instrument will you be playing in marching band? \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Who do you live with?                     Both Parents                     Guardian  
(check one)                                 Mother                                 Father

## Mother's Information:

Name \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

e-mail address (**PLEASE print neatly!**) \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

## Father's Information:

Name \_\_\_\_\_ Date of Birth: \_\_/\_\_/\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

e-mail address (**PLEASE print neatly!**) \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

Below you will find the hot weather practice procedures for our school. Please read this information and sign the second page and return it to your child's coach or return it to the athletic office. Completion of this form is a requirement for participation in our extracurricular programs.

### HOT WEATHER PRACTICE PROCEDURES

<b>LEVEL</b>	<b>HEAT INDEX TEMPERATURES</b>	<b>AFFECTS ON BODY</b>	<b>PRACTICE HOURS</b>	<b>BREAKS</b>	<b>FLUIDS</b>
<b>Caution</b>	80°- 89° F		Use caution	5 minute break every 20 minutes	Cold water
<b>Extreme Caution</b>	90°- 104° F	Cramps or heat exhaustion possible	Use extreme caution	5 minute break every 15 minutes	Cold water
<b>Danger</b>	105°- 129° F	Cramps or heat exhaustion likely, heat stroke possible	Helmets Only Practice time should be shortened with low intensity	5 minute break every 10 minutes	Cold water
<b>Extreme Danger</b>	130°- F and above	Heat stroke highly likely	No Practice	No Practice	Cold water

Heat index readings will be taken at the practice site by a trained staff member using a thermal indicator heat index monitor.

*Rolt Owens*

\_\_\_\_\_  
Band Director's Signature

**NOTE: THE PRINCIPAL OF THE SCHOOL MAY LIMIT PRACTICE AT ANY TIME DUE TO HEAT OR WEATHER RELATED FACTORS.**

**Certificate of Receipt**

**Hot Weather Practice Procedures**

By signing below I, \_\_\_\_\_, parent of  
\_\_\_\_\_, acknowledge that I have received a copy  
of the hot weather practice procedures for my child's school. I understand that I may  
contact the band director or athletic director if I have any questions.

**Parent Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

# Coweta County School System

## Permission for Media Release

STUDENT NAME: \_\_\_\_\_

The Coweta County School System

\_\_\_\_\_ has permission

\_\_\_\_\_ does not have permission

to use my child's photograph, honor roll information, or interview in a positive fashion to publicize news or information concerning the Coweta County School System in print media, on TV or radio, or on the Coweta County School System website during the 2008-2009 school year.

Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature:

\_\_\_\_\_

Date:

\_\_\_\_\_

Please note: This signed release is good for the academic year in which it was signed. A new release must be signed indicating your choice each year your child is a student with the Coweta County School System.

*For Office Use Only*

- Please retain one copy of this form for your records
- Please provide one copy of this form to the local school ETSS or Webmaster

# Preparticipation Physical Evaluation

# HISTORY FORM

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Personal Physician \_\_\_\_\_  
**In case of emergency, contact:**  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ Phone (W) \_\_\_\_\_

**Explain "Yes" answers below.  
Circle questions you don't know the answers to.**

	Yes	No		Yes	No						
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>						
2. Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>						
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>						
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>						
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>						
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>						
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>						
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>						
9. Has a doctor ever told you that you have (check all that apply):			32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/> High blood pressure		<input type="checkbox"/> A heart murmur	33. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/> High cholesterol		<input type="checkbox"/> A heart infection	34. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>						
10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>						
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	36. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>						
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	37. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>						
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>						
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>						
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>						
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>						
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>						
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>						
19. Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>						
Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest	45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>	
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes	46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	47. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>
23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>						48. How old were you when you had your first menstrual period?	_____		
								49. How many periods have you had in the last 12 months?	_____		

**FEMALES ONLY**

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 \_\_\_\_\_

# Preparticipation Physical Evaluation

## PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body Fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ (\_\_\_\_ / \_\_\_\_\_, \_\_\_\_ / \_\_\_\_\_)

Vision R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

\*Multiple-examiner set-up only.  
 +Having a third party present is recommended for the genitourinary examination.

Notes: \_\_\_\_\_  
 \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

**Preparticipation Physical Evaluation**

**CLEARANCE FORM**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Not Cleared for  All sports  Certain sports: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_  
 \_\_\_\_\_

**EMERGENCY INFORMATION**

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

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**Preparticipation Physical Evaluation**

**CLEARANCE FORM**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Not Cleared for  All sports  Certain sports: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_  
 \_\_\_\_\_

**EMERGENCY INFORMATION**

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

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