INSURANCE INFORMATION

Please **INITIAL** one of the following statements regarding insurance coverage for your son/daughter for the 2009-2010 school year, then sign below:

____My son/daughter is adequately and currently covered by accident insurance that will cover injuries sustained while participating in inter-scholastic Athletics (including, but not limited to, Varsity and Junior Varsity Football).

COMPANY PROVIDING INSURANCE____________________________________**NAME OF INSURED**_________________________________

POLICY NUMBER__________________________________**PRIMARY CARE PHYSICIAN'S NAME**____________________________________

____I wish to purchase the Benefit Plan provided by the Cobb County School System. (A copy of this benefit plan is available from the administration.)

Parent or Guardian Signature ____ Date ________________

AUTHORIZATION

I understand that per The Georgia High School Association a **Preparticipation Physical Evaluation** must be performed by a physician to medically screen each student who participates in the athletic programs of the Cobb County School District. I further understand that a basic medical screening (the required physical exam) is general in nature and limited in its scope and does not indicate or assure me that my child is completely free from impairments. If I wish for a more detailed physical exam to be performed upon my child/ward then it is my responsibility to arrange and pay for such an exam. If this more detailed exam is performed, it is my responsibility to notify the Cobb County School District, and its appropriate employees, of any potential medical problems uncovered by any physical exam given to my child/ward other than the general physical required by the school system for athletic participation. I agree to fully waive any and all claims of whatever nature, fully and finally, now and forever, for my child/ward, for myself, my estate, my heirs, my administrators, my executors, my assignees, my agents, my successors, and for all members of my family, and to indemnify, release, defend, exonerate, discharge and hold harmless the Cobb County School District, their schools, their trustees, officers, Board members, Board of Education, employees, agents, coaches, athletic trainers, physicians, and any other practitioner of the healing arts (an "Indemnified Party") from any and all liability, personal or property damages, claims, causes of action or demands brought against the Cobb County School District or indemnified party arising out of any injuries to my child/ ward or to his or her property or losses of any kind which may result from or in connection with his or her participation in any activity related to the athletic programs provided by the Cobb County School District.

My signature below attests that I have read, understand and concur with the information on this form, and that I give consent for my child to participate in the athletic programs as stated above.

Parent or Guardian Signature ____ Date ________________

Relation To Student: (Check One) Mother ___ Father ___ Other ___

Phone Numbers (W) __________________________ (H) ___________________________ (C) _____________________________

CONSENT

(COBB COUNTY SCHOOL DISTRICT PERMISSION TO PARTICIPATE IN ATHLETIC TEAM ONE-DAY SCHOOL SPONSORED TRIPS)

I hereby consent for ____(student's name) to participate in school-sponsored trips, excluding overnight trips, associated with inter-scholastic athletic competitions. I understand that transportation may or may not be provided by the Cobb County School District. In the event transportation is not provided by the Cobb County School District, transportation will be the student's responsibility. If any emergency medical procedures or treatments are required by the student during the trip, I consent to the trip supervisor(s) taking, arranging for, and consenting to the procedures or treatment in his/her discretion.

I release and waive, and further agree to indemnify, hold harmless or reimburse the Cobb County School District, the Board of Education, its successors and assigns, its members, agents, employees and representatives thereof, as well as trip supervisors, from and against, any claim which I, and any other parent or guardian, any sibling, the student, or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, from any losses, damages or injuries arising out of, during, or in conjunction with the student's participation in the activity, any trip associated with the activity, or the rendering or emergency medical procedures or treatment, if any.

Parent or Guardian Signature ____ Date ________________

THIS PAGE **MUST BE SIGNED BY A LICENSED M.D. OR DOCTOR OF OSTEOPATHY**

THE ACTUAL EXAM MAY BE COMPLETED BY A LICENSED MEDICAL PHYSICIAN, DOCOTOR OF OSTEOPATHY, NURSE PRACTITIONER, OR PHYSICIANS ASSISTANT

THE DOCTORS STAMP IS ACEPTABLE IF IT IS IN SCRIPT AND IF THE INFORMATION APPEARS ELSEWHERE ON THE PAGE IDENTIFYING HIM/HER AS A MEDICAL DOCTOR

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*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
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