

## 2023-2024 PITT COUNTY SCHOOLS Athletic Participation Form

STUDENT ATHLETE			PARENT PERMISSION		
Name of Student: (Please Print)			Parents Name: (Please Print)		
School:		Grade:	Street Address:		
Date of Birth:	Phone: Home: Student Cell:	City:	State & Zip Code:	Phone: Home: Work: Cell:	
<p><b>Request for Permission:</b> We, the student's parent/legal custodian, give my consent for the above-named student to represent his/her school in interscholastic sports, <b>EXCEPT</b> for those indicated by listing here _____</p>					
<p><b>Note:</b> Pitt County athletics includes Baseball, Basketball, Cheerleading, Cross Country, Football, Golf, Lacrosse, Soccer, Softball, Swimming, Tennis, Track, Volleyball, Wrestling, Wrestling Matt Maid, Student Athletic Training, Student Team Manager</p>					
<p><b>Risk of Injury:</b> We acknowledge and understand that there is a risk of injury involved in athletic participation. We understand that the student-athlete will be under the supervision and direction of a PCS athletic coach. We agree to follow the rules of the sport and the instructions of the coach in order to reduce the risk of injury to the student and other athletes. However, we acknowledge and understand that neither the coach nor PCS can eliminate the risk of injury in sports. Injuries may and do occur. Sports injuries can be severe and in some cases may result in permanent disability or even death. We freely, knowingly, and willfully accept and assume the risk of injury that might occur from participation in athletics.</p>					
<p><b>Release:</b> In consideration of PCS allowing the student-athlete to participate in athletics, we agree to release and hold PCS, its athletic coaches, contracted personnel, Athletic Trainers, and supervising physicians, harmless and indemnified from and against any and all claims, suits or cases of action arising from or out of any injury that the student-athlete may suffer from participation in athletics other than an injury resulting from gross or willful negligence.</p>					
<p><b>Insurance:</b> Pitt County Schools provides an All-Athletic Insurance policy. This is a secondary insurance policy. These limited benefits will be made available upon request.</p>					
Check one: <input type="checkbox"/> School Accident Insurance or <input type="checkbox"/> Other			Policy Number:		
Name of Other Insurance:					
Street Address:			Policy Term From: To:		
City:	State:	Zip Code:	Group Number:		
<p><b>CERTIFICATION AND MEDICAL AUTHORIZATION:</b> We certify that all of the information provided by us on this form is correct. We agree to abide by state and local rules. We give our consent for the student to receive a medical screening examination prior to participation in athletics. If the student-athlete is injured while participation in athletics and PCS is unable to contact the parent, we grant PCS, contracted personnel, Athletic Trainers, and supervising physicians permission and authority to provide necessary medical care to my child. Treatment may include, but is not limited to, first aid, CPR, medical/surgical treatment recommended by a physician, and invasive diagnostic procedures such as rectal thermometry.</p>					
<p><b>Release of Medical Information:</b> I also give my permission for the treating physician to release information to the athletic trainer/first responder and/or receive health-related information needed to care for my child with physicians, coaches, other healthcare providers, etc. throughout the school year.</p>					
<p>We, the undersigned student and parent, have read this document and understand and agree to the expectations for athletic participation at Pitt County Schools.</p>					
Student:			Date:		
Parent/Custodian:			Date:		

## Athletic Pledge

### Student Athlete Pledge

As a student athlete, I am a role model. Using inappropriate language, taunting, baiting, or using unwarranted physical contact directed at opposing players, coaches, or fans is contrary to the spirit of fair play and the good sportsmanship that my school, my conference, and the North Carolina State Board of Education expect of their members. I accept my responsibility to model good sportsmanship that comes with being a student athlete.

### Parent Pledge

As a parent, I am a role model. I will remember that school athletics are an extension of the classroom, offering learning experiences for the students. I will show respect for the opposing players, coaches, spectators and support groups. I will participate in cheers that support and uplift the teams involved. Using inappropriate language and taunting are contrary to the spirit of fair play and good sportsmanship that our school, our conference and the North Carolina State Board of Education expect of their members. I accept my responsibility to model good sportsmanship that comes with being the parent of a student athlete.

### Affirmation of Domicile and Custody

Only students who meet domicile and custody requirements are eligible to take part in interscholastic competition. Pitt County Schools requires that the following criteria be met:

**Domicile** – Student athletes must attend the school to which they are assigned by the Board of Education. All students, unless granted a transfer according to Board of Education Policy 10.104 or Policy 10.111, must attend their home school, which is the school in the attendance area where they are domiciled.

According to State Law, although a person may have more than one residence, he/she can have only one domicile. Under Pitt County Board of Education Policy 10.103, the domicile of an un-emancipated minor student is deemed to be that of his/her parent or court-ordered custodian. According to Pitt County Board of Education Policy 10.103, domicile is the location where the parent/custodian lives on a permanent or indefinite basis. One can establish a new domicile only by abandoning the current residence of domicile, with no intent to return to it. The entire family must make the change, taking household goods and furniture.

**Custody** – Student athletes must be domiciled in Pitt County with a parent, court-appointed custodian or court-appointed guardian or with a caretaker authorized to enroll the student under NCGS 115C-366 (a3) due to documented parental abandonment, abuse or neglect.

**Penalties** – If a student dresses for or participates in interscholastic competition in violation of the above requirements, the games in which the student took part will be forfeited. Further, the school could be required to forfeit post-season awards; be banned from taking part in contests for a year; and/or be assessed a penalty upon readmission.

If there is documented proof that a student and/or his/her parent or legal custodian have falsified the student's athletic eligibility, the student shall be dropped from the team for the remainder of the season and become ineligible to participate for 365 days.

**Parent/Legal Custodian Statement** – I have read and understand the above domicile and custody requirements for interscholastic competition in Pitt County Schools. I hereby certify that my son/daughter meets these criteria. I further note that it is my responsibility to complete another Domicile and Custody Form if my domicile changes during the academic year. I understand that if I sign this document falsely, I subject my child to the risk of being dropped from the team, and subject the school and the district to the risk of forfeiting games, championships and post-season revenues.

<b>Parent/Custodian:</b>	<b>Date:</b>
<b>Student:</b>	<b>Date:</b>

## Gfeller-Waller NCHSAA Student-Athlete & Parent/Legal Custodian Concussion Information Sheet

**What is a concussion?** A concussion is an injury to the brain caused by a direct or indirect blow to the head. It results in your brain not working as it should. It may or may not cause you to black out or pass out. It can happen to you from a fall, a hit to the head, or a hit to the body that causes your head and your brain to move quickly back and forth.

**How do I know if I have a concussion?** There are many signs and symptoms that you may have following a concussion. A concussion can affect your thinking, the way your body feels, your mood, or your sleep. Here is what to look for:

Thinking/Remembering	Physical	Emotional/Mood	Sleep
Difficulty thinking clearly	Headache	Irritability-things bother you more easily	Sleeping more than usual
Taking longer to figure things out	Fuzzy or blurry vision	Sadness	Sleeping less than usual
Difficulty concentrating	Feeling sick to your stomach/queasy	Being more moody	Trouble falling asleep
Difficulty remembering new information	Vomiting/throwing up	Feeling nervous or worried	Feeling tired
	Dizziness	Crying more	
	Balance problems		
	Sensitivity to noise or light		

*Table is adapted from the Centers for Disease Control and Prevention (<http://www.cdc.gov/concussion/>)*

**What should I do if I think I have a concussion?** If you are having any of the signs or symptoms listed above, you should tell your parents, coach, athletic trainer or school nurse so they can get you the help you need. If a parent notices these symptoms, they should inform the school nurse or athletic trainer.

**When should I be particularly concerned?** If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, or your words are coming out funny/slurred, you should let an adult like your parent or coach or teacher know right away, so they can get you the help you need before things get any worse.

**What are some of the problems that may affect me after a concussion?** You may have trouble in some of your classes at school or even with activities at home. If you continue to play or return to play too early with a concussion, you may have long term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur. Once you have a concussion, you are more likely to have another concussion.

**How do I know when it's ok to return to physical activity and my sport after a concussion?** After telling your coach, your parents, and any medical personnel around that you think you have a concussion, you will probably be seen by a doctor trained in helping people with concussions. Your school and your parents can help you decide who is best to treat you and help to make the decision on when you should return to activity/play or practice. Your school will have a policy in place for how to treat concussions. You should not return to play or practice on the same day as your suspected concussion.

*You should not have any symptoms at rest or during/after activity when you return to play, as this is a sign your brain has not recovered from the injury.*

*This information is provided to you by the UNC Matthew Gfeller Sport-Related TBI Research Center, North Carolina Medical Society, North Carolina Athletic Trainers' Association, Brain Injury Association of North Carolina, North Carolina Neuropsychological Society, and North Carolina High School Athletic Association.*

## Gfeller-Waller NCHSAA Student-Athlete & Parent/Legal Custodian Concussion Statement Form

Instructions: The student athlete and his/her parent or legal custodian, must initial beside each statement acknowledging that they have read and understand the corresponding statement. The student-athlete should initial in the left column and the parent or legal custodian should initial in the right column. Some statements are applicable only to the student-athlete and should only be initialed by the student-athlete. This form must be completed for each student-athlete, even if there are multiple student-athletes in the household.

Student-Athlete Name: (please print) \_\_\_\_\_

Parent/Legal Custodian Name(s): (please print) \_\_\_\_\_

Student-Athlete Initials		Parent/Legal Custodian(s) Initials
	A concussion is a brain injury, which should be reported to my parent(s) or legal custodian(s), my or my child's coach(es), or a medical professional if one is available.	
	A concussion cannot be "seen." Some signs and symptoms might be present immediately; however, other symptoms can appear hours or days after an injury.	
	I will tell my parents, my coach and/or a medical professional about my injuries and illnesses.	Not Applicable
	If I think a teammate has a concussion, I should tell my coach(es), parent(s)/ legal custodian(s) or medical professional about the concussion.	Not Applicable
	I, or my child, will not return to play in a game or practice if a hit to my, or my child's, head or body causes any concussion-related symptoms.	
	I, or my child, will need written permission from a medical professional trained in concussion management to return to play or practice after a concussion.	
	Based on the latest data, most concussions take days or weeks to get better. A concussion may not go away, right away. I realize that resolution from a concussion is a process that may require more than one medical visit.	
	I realize that ER/Urgent Care physicians will not provide clearance to return to play or practice, if seen immediately or shortly after the injury.	
	After a concussion, the brain needs time to heal. I understand that I or my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before concussion symptoms go away.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I have read the concussion symptoms listed on the Student-Athlete/ Parent Legal Custodian Concussion Information Sheet.	
	I have asked an adult and/or medical professional to explain any information contained in the Student-Athlete & Parent Concussion Statement Form or Information Sheet that I do not understand.	

**By signing below, we agree that we have read and understand the information contained in the Student-Athlete & Parent/Legal Custodian Concussion Statement Form, and have initialed appropriately beside each statement.**

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Custodian

\_\_\_\_\_  
Date



## ■ 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: M/F \_\_\_\_\_

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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

(A sum of  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS		Yes	No
(Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)			
1. Do you have any concerns that you would like to discuss with your provider?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has a provider ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any ongoing medical issues or recent illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has a doctor ever told you that you have any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEART HEALTH QUESTIONS ABOUT YOU		Yes	No
(CONTINUED)			
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



# ■ PREPARTICIPATION PHYSICAL EVALUATION

## PHYSICAL EXAMINATION FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

### PHYSICIAN REMINDERS

- 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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ ( _____ / _____ )	Pulse: _____	Vision: R 20/ _____ L 20/ _____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)	<input type="checkbox"/>	
Eyes, ears, nose, and throat • Pupils equal • Hearing	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	
Heart <sup>a</sup> • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck	<input type="checkbox"/>	
Back	<input type="checkbox"/>	
Shoulder and arm	<input type="checkbox"/>	
Elbow and forearm	<input type="checkbox"/>	
Wrist, hand, and fingers	<input type="checkbox"/>	
Hip and thigh	<input type="checkbox"/>	
Knee	<input type="checkbox"/>	
Leg and ankle	<input type="checkbox"/>	
Foot and toes	<input type="checkbox"/>	
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test	<input type="checkbox"/>	

<sup>a</sup> 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 of Examination: \_\_\_\_\_

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 of Examination: \_\_\_\_\_

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

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

### SHARED EMERGENCY INFORMATION

Allergies: \_\_\_\_\_

\_\_\_\_\_  
Medications: \_\_\_\_\_

\_\_\_\_\_  
Other information: \_\_\_\_\_

\_\_\_\_\_  
Emergency contacts: \_\_\_\_\_