



HIGH SCHOOL Affidavit of Eligibility

Eligibility Requirements: To be eligible to participate in high school interscholastic activities, a student must not have reached his 19th birthday prior to September 1st of the current school year. A student has eight (8) consecutive semesters or four (4) consecutive years of eligibility from the date of entry into the 9th grade to be eligible for interscholastic competition. This form is used by The King's Academy Athletic Department to document when the student entered the 9th grade.

Student's name: _____ Date of birth: _____ Current Age: _____

Student entered the 9th grade in the fall of _____ (year) and has 8 consecutive semesters of athletic eligibility from this date. Last year of eligibility will be _____ - _____ (academic year).

Grade as of September 1st of the current academic year _____

Name of school currently enrolled: _____

Is this student enrolled in an online school associated with the Georgia Public School System? _____
If yes, please provide the name of the online school program: _____

Has this student repeated a grade since entering the 9th grade? Yes ___ No ___ If yes, which grade? _____
Reason for repeating a grade: _____

Has this student played varsity sports for another school after entering the 9th grade? Yes ___ No ___
If yes, provide name of school, sport and year played: _____

Is your student currently playing for a coach affiliated with The King's Academy (ie: staff, parent, coach)? If yes, please provide their name: _____

By signing this Affidavit, I hereby certify that all the information provided above is accurate and true and understand that my athletic eligibility will be verified by the Athletic Department.

Player's Signature _____ Date _____

Player's printed name _____

Parent's Signature _____ Date _____

Parent's printed name _____

Georgia Association of Private & Parochial Schools

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Concussion Information and Acknowledgement Form

Parent and Student:

It is important that parents and students are educated about concussions. All concussions are serious, and concussions can occur in any sport.

1. Definition of Concussion: A brain injury that interferes with the normal brain function.
2. Cause of Concussions: A bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth.
3. Signs and Symptoms of Concussions:

Headache Nausea Vomiting Dizziness Confused Sluggish Fatigue Blurry Vision Memory Loss Appears Dazed	Slurred Speech Moves Clumsily Balance Problems Forgets Instruction Numbness/Tingling Loses Consciousness Concentration Problems Slowed Thought Process Difficulty Thinking Clearly	Answers Questions Slowly Sensitivity to Light or Noise Unsure of Game, Score or Opponent Shows Mood, Personality or Behavior Changes Cannot Recall Events Prior To or After Injury
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4. In accordance with Georgia Law, the following must occur if an individual exhibits signs, symptoms or behaviors of a concussion:
 - a. The individual shall be immediately removed from practice or competition.
 - b. The individual suspected of having a concussion shall be seen by an appropriate health care professional before the individual can return to athletic participation.
 - c. The individual shall not return to practice or competition the same day the concussion or suspected concussion occurred.
 - d. If no concussion has occurred, the individual can return immediately to practice or competition
 - e. If a concussion has occurred, the individual cannot return to participation in practice or competition until medically cleared by an appropriate health care professional.
 - f. An individual could never return to participation if the individual still has any symptoms of a concussion.
 - g. After clearance has been issued, the individual's actual return to participation in practice and competition should follow a gradual procedure suggested by the National Federation of High Schools and directed by the appropriate health care provider clearing the athlete for activity.
 - h. An appropriate health care profession may include licensed doctor or another licensed individual under the supervision of a licensed doctor such as a nurse practitioner, physician assistant, or certified athletic trainer who has received training in concussion evaluation and management.
5. The following information can be found online and is recommended for parents and students to read concerning concussions:
 - a. NFHS Suggested Guidelines for Management of Concussion in Sports.
 - b. NFHS, A Parent's Guide to Concussions in Sports
6. Parent and student should sign the form below. The school and parent should maintain a copy of this form.

I have read this form and I understand the facts presented in it.

Parent/Guardian Printed Name

Student Printed Name

Parent/Guardian Signature

Student Signature

Date

Georgia High School Association Student/Parent Sudden Cardiac Arrest Awareness Form



SCHOOL: _____

1: Learn the Early Warning Signs

If you or your child has had one or more of these signs, see your primary care physician:

- Fainting suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks or ringing phones
- Unusual chest pain or shortness of breath during exercise
- Family members who had sudden, unexplained and unexpected death before age 50
- Family members who have been diagnosed with a condition that can cause sudden cardiac death, such as hypertrophic cardiomyopathy (HCM) or Long QT syndrome
- A seizure suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks or ringing phones

2: Learn to Recognize Sudden Cardiac Arrest

If you see someone collapse, assume he has experienced sudden cardiac arrest and respond quickly. This victim will be unresponsive, gasping or not breathing normally, and may have some jerking (Seizure like activity). Send for help and start CP. You cannot hurt him.

3: Learn Hands-Only CPR

Effective CPR saves lives by circulating blood to the brain and other vital organs until rescue teams arrive. It is one of the most important life skills you can learn – and it's easier than ever.

- Call 911 (or ask bystanders to call 911 and get an AED)
- Push hard and fast in the center of the chest. Kneel at the victim's side, place your hands on the lower half of the breastbone, one on top of the other, elbows straight and locked. Push down 2 inches, then up 2 inches, at a rate of 100 times/minute, to the beat of the song "Stayin' Alive."
- If an Automated External Defibrillator (AED) is available, open it and follow the voice prompts. It will lead you step-by-step through the process, and will never shock a victim that does not need a shock.

By signing this sudden cardiac arrest form, I give _____ High School permission to transfer this sudden cardiac arrest form to the other sports that my child may play. I am aware of the dangers of sudden cardiac arrest and this signed sudden cardiac arrest form will represent myself and my child during the 2021-2022 school year. This form will be stored with the athletic physical form and other accompanying form required by the _____ School System.

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

Student Name (Printed)

Student Name (Signed)

Date

Parent Name (Printed)

Parent Name (Signed)

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 assigned at birth: _____

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 ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

(First Name)	GENERAL QUESTIONS		
	(Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)		
		Yes	No
	1. Do you have any concerns that you would like to discuss with your provider?	<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"/>	
3. Do you have any ongoing medical issues or recent illness?	<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"/>	
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<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"/>	
7. Has a doctor ever told you that you have any heart problems?	<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"/>	

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

(Last Name)

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>
MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you ever become ill while exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you or does someone in your family have sickle cell trait or disease?	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you ever had or do you have any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL QUESTIONS (CONTINUED)	Yes	No
25. Do you worry about your weight?	<input type="checkbox"/>	<input type="checkbox"/>
26. Are you trying to or has anyone recommended that you gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
27. Are you on a special diet or do you avoid certain types of foods or food groups?	<input type="checkbox"/>	<input type="checkbox"/>
28. Have you ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>

Explain "Yes" answers here.

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

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2023 This form has been modified for use by the GHSA

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

(First Name)

(Last Name)

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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Pupils equal Hearing 	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Skin <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Double-leg squat test, single-leg squat test, and box drop or step drop test 	<input type="checkbox"/>	

^a 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: _____

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: _____

Address: _____ Phone: _____

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

SHARED EMERGENCY INFORMATION

Allergies: _____

Medications: _____

Other information: _____

Emergency contacts: _____

