



ATHLETIC PARTICIPATION, WAIVER, INSURANCE, AND CONSENT FORM

*Parent/Guardian(s) and Student signature required at bottom of form & initials required as indicated below

PLEASE PRINT

Student Name (Last) (First) (Middle) (Grade Level 2025-26)

Address (Street) (City) (Zip)

(Parent Cell Phone #) (Parent Alternate Phone #) (Year Entered 9th Grade) (Date of Birth)

PARENT/GUARDIAN CONSENT FOR ATHLETIC PARTICIPATION

*Parent/Guardian and Student must both initial in blanks before each bold section below

ACKNOWLEDGEMENT OF RISK: I understand and acknowledge that participation in inter-scholastic sports teams/clubs and events is voluntary and by its very nature possesses an actual or potential risk of emotional and physical injury/illness, which may range in severity from minor to long term catastrophic injury, up to permanent paralysis or death. While it is not possible to eliminate this risk, Students have the responsibility to help reduce the chance of injury. Students must obey all safety rules, report all physical problems to their coaches or supervisors follow a proper conditioning program and inspect equipment daily. Parents/Guardians or Students who do not wish to accept this risk should not sign this form.

INSURANCE COVERAGE: I am aware there is no District insurance coverage for medical treatment of personal injuries or property damage which may arise out of Student's participation in inter-scholastic athletics, sports clubs, and events. I understand my student must have insurance coverage in order to participate.

Please CHECK one of the following statements regarding insurance coverage for Student for the current school year:

Student is adequately and currently covered by accident insurance that will cover injuries sustained while participating in inter-scholastic athletics, sports teams/clubs and events.

Insurance Company: Company Phone Number: Name of Insured: Policy Number:

I wish to purchase the Benefit Plan provided by the Cobb County School System. (A copy of this Benefit Plan should be attached)

PHYSICAL EVALUATION AND MEDICAL TREATMENT: Per Georgia High School Association (GHSA) a Pre-participation Physical Evaluation must be performed by a physician (MD/DO), nurse practitioner or physician assistant to medically screen each student who participates in District athletic programs. I understand that this medical evaluation is general in nature and only performed for purpose of determining fitness for athletics. In case of an emergency or accident on/off school grounds during any school activity or athletic event, which in the opinion of school authorities requires immediate medical or surgical attention, I hereby grant permission to physicians, consulting physicians, certified athletic trainers, emergency medical technicians, and other healthcare providers selected by school authorities to provide medical care and treatment (including hospitalization if deemed appropriate) unless I am present and request otherwise or until I later request otherwise.

REVIEW OF ATHLETIC HANDBOOK (including Board Policy IDF-R Athletic Code of Conduct): I acknowledge that I have reviewed and consent to the guidelines of the Student/Parent Athletic Handbook, which can be found on the Athletics page of the Cobb County School District website (cobbk12.org), the local high school website, or by request of a hardcopy to the local high school. I understand that both Student and Parent/Guardian are subject to the rules outlined in this handbook and that violations may result in school discipline and consequences up to Student's loss of the privilege of athletic participation and/or loss of Parent(s)/Guardian(s)' privilege of attending athletic events. I have read and understand the consequences of certain behavior(s) as outlined in the Code of Conduct.

TRANSPORTATION AND TRAVEL: I acknowledge my understanding of the travel-related guidelines as outlined within the Student/Parent Athletic Handbook, including the responsibility of parent/guardian to arrange transportation when not District-provided. I consent for my student to participate in school-sponsored athletic trips.

Parent/Guardian

Student

WAIVER: I assume all liability and responsibility for any and all potential or real risks, injuries or even death which may result from Student’s participation in inter-scholastic athletics, sports teams/clubs and events. I represent and warrant that I know of no mental or physical condition that would make it unsafe for Student to participate in inter-scholastic athletics, sports teams/clubs, and events. I understand, acknowledge, and agree that the Cobb County School District (CCSD) shall not be liable for any injury/illness suffered by the student which arises out of and/or is associated with preparing for and/or participating in inter-scholastic athletics, sports teams/clubs, and events.

I hereby release, discharge, indemnify, and agree to hold harmless the CCSD District, Members of the CCSD Board of Education, its past, present and future officers, attorneys, agents, employees, predecessors and successors in interest, and assigns, hereinafter “CCSD releasees”, from any and all liability arising out of or in connection with Student’s participation in inter-scholastic athletics, sports teams/clubs and events. For purpose of this Release, liability means all claims, demands, losses, causes of action, suits, or judgments of any kind that Student or Student’s parents, guardians, heirs, executors, administrators, and assigns have or may have against the CCSD releasees because of Student’s personal, physical, or emotional injury, accident, illness or death, or because of any loss of or damage to property that occurs to Student or his or her property during Student’s participation in inter-scholastic athletics, sports teams/clubs and events due to acts of passive or active negligence by CCSD releases other than actions involving fraud or actual malice.

By signing below, you acknowledge that you have carefully read this voluntary Waiver and understand the potential dangers incident to engaging in inter-scholastic athletics, sports teams/clubs, and events, and are fully aware of the legal consequences of this agreement.

SIGNATURE:

By signing below, Parent/Guardian and Student hereby agree to/give consent for participation in inter-scholastic athletics, sports teams/clubs, and events for Cobb County School District of the below-indicated Student. You acknowledge that you have carefully reviewed and agree to all terms of athletic participation, including the voluntary waiver, verify that all information contained herein is accurate, and understand that any false information may result in Student’s ineligibility for athletic participation.

_____	_____	_____
Signature(s) of Parent(s)/Guardian(s)	Printed Name of Parent(s)/Guardian(s)	Date
_____	_____	_____
Signature of Student	Printed Name of Student	Date

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ (First Name) _____ (Last 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"/>	

(Last Name)	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"/>	

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ (First Name) _____ (Last 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 <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: _____

Georgia High School Association Student/Parent Concussion Awareness Form

SCHOOL: Choose one _____

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.

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.

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.

By signing this concussion form, I give Choose one _____ High School permission to transfer this concussion form to the other sports that my child may play. I am aware of the dangers of concussion and this signed concussion form will represent myself and my child during the 2025-2026 school year. This form will be stored with the athletic physical form and other accompanying forms required by the _____ School System.

COBB COUNTY

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

Georgia High School Association

Student/Parent Sudden Cardiac Arrest Awareness Form

SCHOOL: Choose one _____

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 CPR. 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 Choose one _____ 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 2025-2026 school year. This form will be stored with the athletic physical form and other accompanying forms required by the _____ School System.

COBB COUNTY

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