

## 2017-2018 DURHAM ATHLETIC CONFERENCE ELIGIBILITY, CONSENT TO PARTICIPATE AND RELEASE FORM

**THIS DOCUMENT MUST BE SIGNED BY THE STUDENT-ATHLETE OF AN NCHSAA MEMBER SCHOOL AND BY THE STUDENT'S PARENT OR LEGAL CUSTODIAN BEFORE PARTICIPATION. STUDENTS MAY NOT PARTICIPATE WITHOUT THE STUDENT'S AND PARENT'S/LEGAL CUSTODIAN'S SIGNATURE.**

I have read, understand and acknowledge receipt of the North Carolina High School Athletic Association's Eligibility Rules. I understand that a copy of the NCHSAA Handbook is on file with the member school's principal and/or Athletic Director, and that I may review it, in its entirety if I so choose. I know my school is a member of the NCHSAA and must adhere to all regulations that govern interscholastic athletic programs, including, but not limited to, Federal and State laws, local regulations and those imposed by the NCHSAA. I understand that local rules may be more stringent than the NCHSAA and agree to follow the rules of my school and the NCHSAA and to abide by their decisions. I acknowledge and understand that participation in interscholastic athletics is a privilege, not a right. I understand that classroom performance, dropping a class or taking coursework through other educational options could affect eligibility and compliance with NCHSAA academic standards.

### STUDENT CODE OF RESPONSIBILITY

As a student athlete, I **understand and accept** the following responsibilities:

I will **respect the rights and beliefs** of others and will treat others with courtesy and consideration.

I will be **fully responsible** for my own actions and the consequences of my actions.

I will **respect the property** of others.

I will **respect and obey the rules** of my school and laws of my community, state and country.

I will **show respect to those who are responsible for enforcing the rules** of my school and the laws of my community, state and country.

I **understand that a student whose character or conduct violates** the school's Athletic Code or School Code of Responsibility could be deemed ineligible for a period of time as determined by the principal or school system Administration

**PARENTS, LEGAL CUSTODIANS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM.** The student and parent/legal custodian recognize that

participation in interscholastic athletics involves some inherent risks for potentially severe injuries including, but not limited to, serious neck, head and spinal injuries, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system, serious injury or impairment to other aspects of the body, or effects to the general health and well-being of the child, and in rare cases death. Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate all risk. Because of these inherent risks, the student and their parent/legal custodian have a responsibility to help reduce that risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily.

I authorize medical treatment should the need arise for such treatment while I or my child/ward ("student-athlete") is under the supervision of the member school. I **consent to medical treatment** for the student-athlete following an injury or illness suffered during practice and/or a contest. I understand that in the case of **injury or illness requiring treatment by medical personnel and transportation to a health care facility**, that a reasonable attempt will be made to contact the parent/legal custodian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be treated and transported via ambulance to the nearest hospital. I further authorize the use or disclosure of my student-athlete's personally identifiable health information should treatment for illness or injury become necessary.

I **understand all concussions are potentially serious** and may result in complications including prolonged brain damage and death if not recognized and managed properly. Further, I understand that if my student is removed from a practice or competition due to a suspected concussion, he or she will be unable to return to participation that day. After that day, written authorization from a physician (M.D. or D.O.) or an athletic trainer working under the supervision of a physician will be required before the student is allowed to return to participation. I also acknowledge that I **have received, read and signed the Gfeller-Waller Concussion Information Sheet.**

I **consent to the NCHSAA's use of the herein named student's name, likeness, and athletic-related information** in reports of contests, promotional

literature of the Association and other materials and releases related to interscholastic athletics and grant the NCHSAA the right to photograph and/or videotape the participant and further to use the participant's face, likeness, voice and appearance in connection with exhibitions, publicity, advertising, promotional and commercial materials without reservation or limitation. The NCHSAA, however, is under no obligation to exercise said rights herein. I further consent to the disclosure, by the member school, to the NCHSAA, upon its request, of all records relevant to the student athlete's athletic eligibility including, but not limited to, their records relating to enrollment, attendance, academic standing, age, discipline, finances, residence and physical fitness. The student and parent/legal custodian individually and on behalf of the student, hereby irrevocably, and unconditionally release, acquit, and discharge, without limitation, the NCHSAA its officers, agents, attorneys, representatives and employees (collectively, the "Releasees") from any and all losses, claims, demands, actions and causes of action, obligations, damages, and costs or expenses of any nature (including attorney's fees) that the student and/or legal custodian incur or sustain to person, property or both, which arise out of, result from, occur during or are otherwise connected with the student's participation in interscholastic athletics if due to the ordinary negligence of the Releasees.

**By signing this document, we acknowledge that we have read the above information and that we consent to the herein named student's participation. We understand that the authorizations and rights granted herein are voluntary and that we may revoke any or all of them at any time by submitting said revocation in writing to the participant's member school. By doing so, however, we understand that the participant will no longer be eligible for participation in interscholastic athletics.**

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Student's Signature	Date of Birth	Grade in School	Date
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Signature of Parent or Legal Custodian	Date
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# NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION SPORT PREPARTICIPATION EXAMINATION FORM

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_

*This is a screening examination for participation in sports. This does not substitute for a comprehensive examination with your child's regular physician where important preventive health information can be covered.*

**Athlete's Directions:** Please review all questions with your parent or legal custodian and answer them to the best of your knowledge.

**Parent's Directions:** Please assure that all questions are answered to the best of your knowledge. Not disclosing accurate information may put your child at risk during sports activity.

**Physician's Directions:** We recommend carefully reviewing these questions and clarifying any positive answers.

Explain "Yes" answers below	Yes	No	Don't know
1. Has the athlete ever been hospitalized or had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the athlete presently taking any medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the athlete have any allergies (medicine, bees or other stinging insects, latex)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the athlete ever passed out or nearly passed out DURING exercise, emotion or startle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the athlete ever fainted or passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the athlete had extreme fatigue associated with exercise (different from other children)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the athlete ever had trouble breathing during exercise, or a cough with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the athlete ever been diagnosed with exercise-induced asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever told the athlete that they have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a doctor ever told the athlete that they have a heart infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has a doctor ever ordered an EKG or other test for the athlete's heart, or has the athlete ever been told they have a murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has the athlete ever had discomfort, pain, or pressure in his chest during or after exercise or complained of their heart "racing" or "skipping beats"?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has the athlete ever had a head injury, been knocked out, or had a concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Has the athlete ever had a seizure or been diagnosed with an unexplained seizure problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Has the athlete ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Has the athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Has the athlete ever had any problems with their eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Has the athlete ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Chest <input type="checkbox"/> Hip <input type="checkbox"/> Forearm <input type="checkbox"/> Shin/calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Hand <input type="checkbox"/> Foot			
19. Has the athlete ever had an eating disorder, or do you have any concerns about your eating habits or weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Does the athlete have any chronic medical illnesses (diabetes, asthma, kidney problems, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Has the athlete had a medical problem or injury since their last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Does the athlete have the sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>FAMILY HISTORY</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Has any family member had a sudden, unexpected death before age 50 (including from sudden infant death syndrome [SIDS], car accident, drowning)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Has any family member had unexplained heart attacks, fainting or seizures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Does the athlete have a father, mother or brother with sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Elaborate on any positive (yes) answers: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*I have reviewed and answered each question above, and assure that all are accurate responses. Furthermore, I give permission for my child to participate in sports.*

Signature of parent/legal custodian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Athlete: \_\_\_\_\_ Date: \_\_\_\_\_ Phone #: \_\_\_\_\_

Athlete's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ ( \_\_\_\_\_ 90 file) / \_\_\_\_\_ ( \_\_\_\_\_ 90 file) Pulse \_\_\_\_\_

Vision R 20: \_\_\_\_\_ L 20: \_\_\_\_\_ Corrected: Y N

These are required elements for all examinations			
	NORMAL	ABNORMAL	ABNORMAL FINDINGS
PULSES			
HEART			
LUNGS			
SKIN			
NECK/BACK			
SHOULDER			
KNEE			
ANKLE/FOOT			
Other Orthopedic Problems			

Optional Examination Elements - Should be done if history indicates			
HEENT			
ABDOMINAL			
GENITALIA (MALES)			
HERNIA (MALES)			

Clearance\*\*:  
 A. Cleared  
 B. Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
 C. Not cleared for:  Collision  Contact  
 Non-contact  Strenuous  Moderately strenuous  Non-strenuous  
 Due to: \_\_\_\_\_

Additional Recommendations/Rehab Instructions: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name of Physician/Extender: \_\_\_\_\_

Signature of Physician/Extender \_\_\_\_\_ MD DO PA NP  
 (Signature and circle of designated degree required)

Date of exam: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_

Physician Office Stamp:

(\*\* The following are considered disqualifying until appropriate medical and parental releases are obtained: post-operative clearance, acute infections, obvious growth retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, a chronic musculoskeletal condition that limits ability for safe exercise/sport (i.e. Klippel-Feil anomaly, Sprengel's deformity), history of convulsions or concussions, absence of or one kidney, eye, testicle or ovary, etc.)  
 This form approved by the North Carolina High School Athletic Association Sports Medicine Advisory Committee December 2009, and the NCHSAA Board of Directors reviewed annually.

**Durham Public Schools**  
**Assumption of Risk/Medical Treatment Release**

Student Athlete's Name \_\_\_\_\_  
School \_\_\_\_\_  
Sport(s) \_\_\_\_\_ Date \_\_\_\_\_

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The Durham Public Schools system makes every effort to prevent injuries, but injuries do occur in athletics. By signing below, I (Parent/Guardian Name) \_\_\_\_\_ do understand:

1. The rules and procedures of the sports listed above and am aware of the risks involved in playing them
2. The necessity of using the proper techniques and protective equipment (when needed).

I recognize that there are inherent risks in all athletic events (head and spinal cord injuries, fractures, internal injuries, etc.) and hereby give my permission for my son/daughter to participate in any and all interscholastic athletic events sponsored by Durham Public Schools.

Permission is hereby granted to Durham Public Schools and its authorized representatives to initiate treatment and rehabilitation of injuries and authorize any needed emergency major medical or minor surgical treatment, x-ray, examination, and immunization of the above named participant by appropriate medical personnel. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that every attempt will be made by the physician to contact me in the most expeditious manner possible. If said physician is unable to communicate with me, the treatment necessary for the best interest/safety of the above named individual may be rendered.

I hereby release the Durham Public Schools system, local/individual school personnel, and the individual members of each athletic department including, but not limited to, its coaches, certified athletic trainers, first responders, student athletic trainers, athletic training student aides, administrators, attending physicians, and all other connected with school athletic activities, from any and all damages for injuries sustained by my son/daughter while participating in any sports activity associated with Durham Public Schools. I do, hereby, agree to hold harmless any and all the above from any and all damages which they may suffer as a result of injuries sustained by my son/daughter while participating as above stated.

\*\*\*\*\*

Are you presently taking any medications, supplements, or pills? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list: \_\_\_\_\_

Does student named above have any allergies? (medicines, bee stings, hay fever, etc.) Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list: \_\_\_\_\_

Parent/Guardian Contact: Name \_\_\_\_\_

Phone #: Primary \_\_\_\_\_ Secondary \_\_\_\_\_ Cell \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_

Phone #: Primary \_\_\_\_\_ Secondary \_\_\_\_\_ Cell \_\_\_\_\_

**SIGNATURE:** (Parent/Guardian): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

Please Read the Following Form Carefully

Authorization For Release of Protected Health Information For Athletic Participating  
In Durham Public Schools Athletics Program

Once properly signed, this authorization will allow for the release of protected health information to the Durham Public Schools Systems (DPS) by physicians and health care providers (Providers) rendering services to DPS athletes. The purpose of the release of the protected health information is to allow the DPS Athletic Program to determine the advisability of an athlete's participation in DPS athletics. An example would be the release of a screening physical examination.

By signing this Authorization for my son, daughter or other person for whom I have legal authority to act (hereinafter referred to as "Athlete"), I hereby authorize health care providers (including, but not limited to, the Duke University Sports Medicine Program and its physicians and providers) that are contracted with DPS to release to each other and to the DPS oral and written medical information relating to the Athlete's medical or physical condition, illness or injury that may have a bearing upon past, present, or future participation in athletics of DPS Athletic Program. The medical information should be used by the DPS Athletic Program for the purpose of determining the advisability of the Athlete's participation in DPS athletics.

This authorization is expressly bound by all the following conditions:

This Authorization will automatically expire upon the Athlete's termination of participation or ineligibility in DPS Athletics, except to the extent relied upon for disclosures made prior to the automatic expiration.

This Authorization may be revoked at any time, provided the revocation is a properly executed written document and delivered to the Director of Athletics for Durham Public Schools. As soon as practicable, DPS shall inform each contracted health care provider prior of each Athlete's revocation. However, any such revocation shall not affect disclosures made by a health care provider prior to that health care provider's receipt of the revocation for DPS. In addition, such revocation shall not affect disclosures made prior to the receipt of the revocation to the extent that this Authorization was relied upon for such affect disclosures made prior to the receipt of the revocation to the extent that this Authorization was relied upon for such disclosures.

This Authorization is not intended to alter the Athlete's ability to receive medical care from any health care provider regardless of whether this Authorization is agreed to or refused.

This Authorization shall cover actions by and for Duke University, Duke University Health System, Inc. and Private Diagnostic Clinic, PLLC, and all of their respective employees, workforce, and business associates, and all other physicians and health care providers contracted with DPS and their respective employees, workforce, and business associates. For a complete list of contracted health care providers for DPS that may release medical information pursuant to the Authorization, please contact Durham Public Schools.

The athlete and Parent/Guardian will receive a complete copy of the signed Authorization.

A copy of this Authorization and any revocation of it will be kept by both the Duke Sports Medicine Office, Durham Public Schools and other health care providers contracted with Durham Public Schools.

Protected health information released by the health care providers to Durham Public Schools is not protected by this Authorization from re-disclosure by Durham Public Schools.

Date: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Athlete

\_\_\_\_\_  
Athlete's Name - Printed

## Student-Athlete & Parent Legal Custodian Concussion Statement

*\*If there is anything on this sheet that you do not understand, please ask an adult to explain or read it to you.*

Student-Athlete Name: \_\_\_\_\_

*This form must be completed for each student-athlete, even if there are multiple student-athletes in each household.*

Parent Legal Custodian Name(s): \_\_\_\_\_

= We have read the *Student-Athlete & Parent Legal Custodian Concussion Information Sheet*.  
*If true, please check box*

After reading the information sheet, I am aware of the following information:

Student-Athlete Initials		Parent/Legal Custodian Initials
	A concussion is a brain injury, which should be reported to my parents, my coach(es), or a medical professional if one is available.	
	A concussion can affect the ability to perform everyday activities such as the ability to think, balance, and classroom performance.	
	A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.	
	I will tell my parents, my coach, and/or a medical professional about my injuries and illnesses.	N/A
	If I think a teammate has a concussion, I should tell my coach(es), parents, or medical professional about the concussion.	N/A
	I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.	N/A
	I will/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 this injury is a process and may require more than one medical evaluation.	
	I realize that ER/Urgent Care physicians will not provide clearance if seen right away after the injury.	
	After a concussion, the brain needs time to heal. I understand that I am/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 on the Concussion Information Sheet.	

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

\_\_\_\_\_  
 Date

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

\_\_\_\_\_  
 Date

# CONCUSSION

## INFORMATION FOR STUDENT-ATHLETES & PARENTS/LEGAL CUSTODIANS

**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.

Do not return to play if you have any symptoms, signs or disorientation, and only when you return to play, as this is the only way to know you are safe 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.*