Parents, Guardians, and Rising 8th/9th Grade Student-Athletes:

My name is Coach Angel. I am an Assistant Football Coach and the Head Wrestling Coach at Loganville High School. I am writing to inform you of spring weightlifting that is being offered for all rising 8th and 9th (current 7th and 8th) grade students after school. Below you will find more information about where and when we will be lifting.

This weightlifting opportunity is to introduce our Middle School student-athletes to safety in the weight room, proper technique/fundamentals, and a weightlifting program that all student-athletes at Loganville Middle School and future Loganville High School Red Devil Athletes need to understand.

Weightlifting is a vital part of our athlete’s development that will help to lead them to more success during their athletic careers. Please take advantage of this opportunity beginning Tuesday, March 3 and ending Thursday, May 7.

If you have any questions feel free to contact me or Dr. Bolemon.
ryan.angel@walton.k12.ga.us
bbolemon@walton.k12.ga.us

WHAT: Loganville Middle/High School Weight Training

WHO: 7th and 8th grade Student-Athletes

WHEN: Every Tuesday & Thursday starting March 3 until May 7 (Will have Spring Break off).

TIME: Weight Training 3:15pm to 4:45pm

WHERE: LHS Football Field House (will take bus over)

MUST HAVE: Current Physical, Sudden Cardiac Awareness Form, and Insurance Waiver on file (turn in all forms first day at weight lifting)

Go Red Devils!

Ryan Angel

Loganville High School
Head Wrestling Coach
Varsity Assistant Football Coach
Loganville High School
Football Weight Training & Spring Practice
7th & 8th Graders BUS PASS

WHAT: Football Weight Training/Speed and Agility & Spring Practice
WHO: 7th & 8th Graders playing football
WHEN: Every Tuesday & Thursday starting March 3 until May 7
TIME: Weight Training 3:15pm to 4:45pm Spring Practice - to be announced

NOTE: (must be picked up on time or will not be able to come back)
WHERE: LHS Football Field House (will take bus over – see Bus Pass Instructions)
MUST HAVE: Insurance Waiver, Concussion Awareness Form, Sudden Cardiac Arrest Form (in player packet - Complete and turn in first day at weight lifting)
Physical - must have a current physical on file (one is included in player packet for you to get done - turn in first day at weight training)

BUS PASS: If participating, you will need to obtain a bus pass (mandatory) from the front office allowing you to get on and off the bus for weight training. Your parents just need to sign bottom of this form as your permission to participate in weight training. For people already riding a bus that goes to LHS, just ride your normal bus. For people that do not ride a bus or rides one that does not go to LHS, the bus to ride will be either 109 or 117. Without a bus pass, you are not allowed to ride bus or participate in weight training.

What to Wear:
➢ Sneakers, T-shirt, Shorts, Socks, and something to drink.

Front Office (please cut between the lines and staple to the bus pass)

My child _____________________________ has my permission to attend weight training on Tuesday and Thursday from March 3 to May 7. He will either ride his own bus if he is currently a bus rider and the bus goes to LHS or he will be riding bus 109 or 117 (see bus pass for bus number). Please accept this as my agreement to issue him a bus pass. I also understand that my child will need to be picked up on time on these days. Failure to do so may be cause for my child to be removed from weight training privileges.

Parent Signature (required) _____________________________ 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 (F, M, or intersex): ___________________________ How do you identify your gender? (F, M, or other): ___________________________

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)

- Feeling nervous, anxious, or on edge
- Not being able to stop or control worrying
- Little interest or pleasure in doing things
- Feeling down, depressed, or hopeless

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

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? | | |
2. Has a provider ever denied or restricted your participation in sports for any reason? | | |
3. Do you have any ongoing medical issues or recent illness? | | |

HEART HEALTH QUESTIONS ABOUT YOU

Yes | No
--- | ---
4. Have you ever passed out or nearly passed out during or after exercise? | | |
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? | | |
7. Has a doctor ever told you that you have any heart problems? | | |
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. | | |

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)

Yes | No
--- | ---
9. Do you get light-headed or feel shorter of breath than your friends during exercise? | | |
10. Have you ever had a seizure? | | |
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)? | | |
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)? | | |
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? | | |
### Bone and Joint Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Have you had a bone, muscle, ligament, or joint injury that bothers you?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Medical Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Do you cough, wheeze, or have difficulty breathing during or after exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Have you ever become ill while exercising in the heat?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Do you or does someone in your family have sickle cell trait or disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Have you ever had or do you have any problems with your eyes or vision?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Medical Questions (Continued)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. Do you worry about your weight?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Are you trying to or has anyone recommended that you gain or lose weight?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Are you on a special diet or do you avoid certain types of foods or food groups?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Have you ever had an eating disorder?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Females Only

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>29. Have you ever had a menstrual period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. How old were you when you had your first menstrual period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. When was your most recent menstrual period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. How many periods have you had in the past 12 months?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Explain “Yes” answers here.*

<table>
<thead>
<tr>
<th>Explanation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: _______________________________________________________

# PREPARTICIPATION PHYSICAL EVALUATION

## PHYSICAL EXAMINATION FORM

**Name:** ____________________________  **Date of birth:** ____________________________

**PHYSICIAN REMINDERS**

1. 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?

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

## EXAMINATION

<table>
<thead>
<tr>
<th>Height:</th>
<th>Weight:</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP: / /</td>
<td>Pulse:</td>
</tr>
<tr>
<td>Vision: R 20/</td>
<td>L 20/</td>
</tr>
<tr>
<td>Corrected: Y N</td>
<td></td>
</tr>
</tbody>
</table>

### MEDICAL

<table>
<thead>
<tr>
<th>Appearance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlexicity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eyes, ears, nose, and throat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pupils equal</td>
</tr>
<tr>
<td>Hearing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lymph nodes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Heart*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lungs</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Abdomen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
</tr>
<tr>
<td>- Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or linea corporis</td>
</tr>
</tbody>
</table>

### NEUROLOGICAL

<table>
<thead>
<tr>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
</table>

### MUSCULOSKELETAL

<table>
<thead>
<tr>
<th>Neck</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back</td>
</tr>
<tr>
<td>Shoulder and arm</td>
</tr>
<tr>
<td>Elbow and forearm</td>
</tr>
<tr>
<td>Wrist, hand, and fingers</td>
</tr>
<tr>
<td>Hip and thigh</td>
</tr>
<tr>
<td>Knee</td>
</tr>
<tr>
<td>Leg and ankle</td>
</tr>
<tr>
<td>Foot and toes</td>
</tr>
<tr>
<td>Functional</td>
</tr>
<tr>
<td>- Double-leg squat test, single-leg squat test, and box drop or step drop test</td>
</tr>
</tbody>
</table>

* Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

## Signature

**Name of health care professional (print or type):** ____________________________  **Date:** ____________________________

**Address:** ____________________________  **Phone:** ____________________________

**Signature of health care professional:** ____________________________
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: _____________________________________

_______________________________________________________

STUDENT/PARENT CONCUSSION AWARENESS FORM

SCHOOL:

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 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 part of the medical clearance.
  c) It is mandatory that every coach in each GHSA sport participate in a free, online course on concussion management prepared by the NFHS and available at www.nfhslearn.com at least every two years – beginning with the 2013-2014 school year.
  d) Each school will be responsible for monitoring the participation of its coaches in the concussion management course, and shall keep a record of those who participate.

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

PRINT: ____________________________ (Students Name) ____________________________ (Date)

SIGNED: ____________________________ (Student Signature) ____________________________ (Parent or Guardian Signature)
WALTON COUNTY PUBLIC SCHOOLS

RELEASE OR INSURANCE FORM

TO WHOM IT MAY CONCERN:

PLEASE BE ADVISED that my son/daughter, __________________________

has permission to participate in __________________________ activity sponsored

by the Walton County Public Schools, Walton, Georgia.

To participate in any athletic activity, a student is required to have a physical

examination signed and dated by a physician before any practice, tryout, or conditioning.

SHOULD EMERGENCY medical treatment be necessary during the course of this activity, I,

_______________________________, hereby authorize the responsible adult designated in

charge of said activity to seek and approve any medical attention needed.

FURTHERMORE, I hereby release the Walton County Public Schools and the school

involved of all responsibility concerning this matter.

STUDENT'S NAME: ____________________________________________

PARENT/GUARDIAN: ____________________________________________

ADDRESS: ___________________________________________________

CITY: ___________________________ ZIP: _________________________

HOME PHONE: ______________________ WORK PHONE: _______________

NAME OF INSURANCE (HEALTH) PROVIDER: ______________________

DATE AUTHORIZED: ____________________________________________

PARENT SIGNATURE: __________________________________________
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 "Staying 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 2020-2021 school year. This form will be stored with the athletic physical form and other accompanying forms 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

(Revised: 2/20)