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SPORTS PHYSICALS



PLEASE NOTE: All 8 pages of the Sports Physical must be filled out completely and signed by student, parent and physician. Student-athletes will not be permitted to participate in any team sport until the Sports Physical is on file in the Athletic Office.



MEMORIAL DAY SCHOOL
ATHLETIC DEPARTMENT
REQUIRED PHYSICAL EXAMINATION FORMS

Dear Parent or Guardian:

ANY student who is interested in participating in our varsity athletic program **MUST** have a physical on file in the athletic office before they will be allowed to participate in any official practice or game.

This physical is not the same as a regular physical exam administered by our family physician. It is a screening to ensure that your child is medically eligible for participation in accordance with our association's guidelines. Memorial Day School recommends that every child receive a regular physical exam from his / her primary care physician to ensure general good health.

You will notice **8** pages attached. Please follow the instructions carefully as listed below:

- [1] **MEMORIAL DAY SCHOOL <> PLAYER – PARENT CONTRACT**
- [2] **PARENT / STUDENT-ATHLETE COMMITMENT FORM**
- [3] **PERMISSION & MEDICAL RELEASE FORM**
Fill out this form and have it signed in three (3) places by both the athlete and the parent / guardian.
- [4] **EMERGENCY CONTACT & INSURANCE INFORMATION**
This form is important should an emergency arise. Please fill this page out completely.
- [5] **PREPARTICIPATION PHYSICAL EVALUATION <> HISTORY FORM**
This form must be completed and signed by both the athlete and parent / guardian.
- [6] **PREPARTICIPATION PHYSICAL EVALUATION <> PHYSICAL EXAMINATION FORM**
This is one form that must be completed and signed by the examining physician.
- [7] **PREPARTICIPATION PHYSICAL EVALUATION <> CLEARANCE FORM**
This is the other form that must be completed and signed by the examining physician.
- [8] **CONCUSSION MANAGEMENT AND RETURN TO PLAY POLICY**
This should be read by both the player and the parents and signed by both.

When all of these forms are completed, please return them to your athlete's coach or the school office.

Thank you for your cooperation.

MARK A. SUSSMAN
Athletic Director

MEMORIAL DAY SCHOOL <> PLAYER – PARENT CONTRACT

It is important to the administration and the athletic coaching staff of Memorial Day School that our teams develop, displays and promotes professionalism at all times. Therefore, standards and expectations have been established to help student-athletes stay focused on goals. Each team's coaching staff will develop and implement rules and consequences hold their team members accountable.

All student-athletes and their parents are asked to sign this Player – Parent Contract confirming their acknowledgement, understanding and support of our expectations, rules and consequences for noncompliance.

I. PLAYER EXPECTATIONS:

- A. *Punctuality. BE EARLY to dress, socialize and stretch. Time posted is the time PRACTICE BEGINS.*
- B. *WORK HARD – and expect HARD WORK to be asked of you.*
- C. *Display and maintain a POSITIVE ATTITUDE at all times.*
- D. *Dedicate yourself to learning and/or improving a skill EVERY DAY.*
- E. *Place the TEAM'S goals ahead of your own personal goals. (ALTRUISTIC vs. EGOCENTRIC)*
- F. *Our schedule will not be easy. RESPECT all – but FEAR none*
- G. *This team is a FAMILY. ENCOURAGE your teammates. Do not tear them down on the field, at school, when you away from them or online.*
- H. *Discuss any questions or concerns with your coach in a positive and mature manner.*
- I. *REPRESENT this program appropriately on the field, in the classroom and in the community.*
- J. *As an athlete, you are expected to take care of your bodies. This includes proper nutrition, stretching, conditioning, as well as refraining from risky substances or activities.*
- K. *Remember your priorities: Faith, Family, Academics, Team and other activities.*

II. PARENT EXPECTATIONS:

- A. *RELINQUISH your coaching responsibilities. Allow the coaches to do their job.*
- B. *Promote LOYALTY and TRUST towards the program's mission and coaches.*
- C. *Place the TEAM'S goals ahead of your own personal goals. (ALTRUISTIC vs. EGOCENTRIC)*
- D. *Practice mutual RESPECT and SUPPORT with the coaches.*
- E. *REPRESENT this program appropriately on the field, in the stands and in the community.*
- F. *Be active in fundraising and teambuilding events.*
- G. *Please DO NOT ATTEND practices or workouts.*
- H. *NEVER CONFRONT a coach regarding any matter before or after a practice or game.*
- I. *Topics NOT OPEN TO DISCUSSION with coaches:*
 1. *Playing Time*
 2. *Team Strategy*
 3. *Play Calling*
- J. *If any conflicts or concerns arise, they are to be resolved via the following procedure:*
 1. *STEP 1 – Player should approach the immediate coach and schedule a time to discuss question or concern. If player does not feel comfortable and satisfied with the outcome of this meeting, proceed to Step 2.*
 2. *STEP 2 – Player should request a meeting with his or her self, the coach and the head coach. If player does not feel comfortable and satisfied with the outcome of this meeting, proceed to Step 3.*
 3. *STEP 3 – A meeting of the player, coaches and parents of the player should be requested via E-Mail to the Head Coach. If meeting does not resolve the situation, the player and parent should proceed to Step 4.*
 4. *STEP 4 - A meeting of the player, coaches, parents of the player and Athletic Director should be requested via E-Mail to the Athletic Director (and copied to all included parties). If all parties are still not comfortable with the situation, a meeting including additional levels of administration should be requested to discuss an alternative solution.*

I, _____, upon signing this team contract, hereby promise to do my best in thought, word and deed and to commit myself to the mission and goals of the Memorial Day School Athletic Program. I am aware that any behavior that portrays a negative perception of me or my team could be reviewed by the coaching staff and administration for possible on-field penalties, suspension or dismissal from the team.

Player Signature

Date

Parent Signature

Date

Parent email address

Parent contact phone number

**MEMORIAL DAY SCHOOL <> ATHLETIC DEPARTMENT
Parent / Student-Athlete Commitment Form**

Athlete's Last Name

First Name

Grade

Sport(s): _____

Dear Parents and Student-Athletes:

We are pleased that your student athlete has the opportunity to participate in athletics at Memorial Day School. We feel it is very important to share some basic guidelines regarding the commitment both you and your student-athlete are about to make and thereby, have your support throughout the season(s).

We hope you have considered both the benefits and constraints involved in being a team member. Each athletic season consists of weeks of practices, games and travel. Our coaching staff will make every effort to plan and organize the entire season and we will advise you of practice times, game dates and travel arrangements.

We have listed items below that each parent and student-athlete need to be aware of. It is the parent's and athlete's responsibility to become aware of the commitment, rules and regulations of being on an athletic team.

1. Be certain your student-athlete is committed to participating at this level of competition and is willing to give the time and effort both at practices and games throughout the entire season
2. Consider the time spent on sports and the impact on your family as well as on study time. Also consider other activities in your life that will be impacted such as church activities, other sports teams and other school involvement. Your student-athlete will be expected to attend and participate in all practices and all games including those scheduled during school holidays. The team needs and must have your commitment to be successful.
3. Realize that there is potential for injury in any sport. Your medical coverage should be up-to-date before the season begins.
4. Be cognizant of the coach's requirements and expectations so you can better understand his / her methods and emphasis.
5. Parents, consider and discuss with your student athlete that their conduct should reflect and reinforce the values and rules of our school. These rules will be enforced not just during the school day, but at all athletic events.
6. Evaluate the financial cost for participation on the team.
7. As a parent, be willing to support the team in whatever way you can (i.e. refreshments, encouragement, attendance at contests, etc.)
8. Realize to quit a team is something the coaches and the athletic department heartily discourage and should not be done without considering the ramifications. Student-Athletes who make the commitment to play for one of our Varsity teams, only to quit before the end of the season (playoffs included), may be denied joining any other Varsity team.

My signature below indicates that I have read this document and have discussed it with my student athlete.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

Student-Athlete Signature

Date

**MEMORIAL DAY SCHOOL
PERMISSION & MEDICAL RELEASE FORM**

ATHLETE'S LAST NAME: _____, FIRST NAME: _____ MI: _____

ASSUMPTION OF RISK

I am aware playing or practicing to play / participate in any sport or sport related activity could be a dangerous activity involving **MANY RISKS OF INJURY**. I understand that the dangers and risks of playing or practicing to play / participate in sports or sport related activity include, but are not limited to: death; serious neck and spinal injuries that may result in complete or partial paralysis; brain damage; serious injury to virtually all bones, joints, ligaments, muscles, tendons, other aspects of the musculoskeletal system and vital organs; and serious impairment to other aspects of the body, general health, and well-being. I understand the dangers and risks of playing or practicing to play / participate in any sport or sport related activity may result not only in serious injury, but in a serious impairment of my (the participant's) future abilities to earn a living; to engage in other business, social and recreational activities; and generally enjoy life. Because of the dangers of playing or practicing to play / participate in any sport or sport related activity, I recognize the importance of following the coach's, official's and medical staff's instructions regarding playing techniques, training, and other team rules, etc., and agree to obey such instructions.

As the parent / legal guardian of the above named participant, I have read the above warnings and release, and understand its terms. I hereby agree to hold Memorial Day School, its direct and contracted employees, agents, representatives, coaches and volunteers, harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever that may arise by or in connection with participation of my child in any activities related to Memorial Day School activities. The terms hereof will serve as a release for my heirs, estate, executor, administrator, assignees, and for all members of my family. Whenever injury and / or sickness occur to the participant listed above, and the participant is under the supervision of Memorial Day School, and the participant's parent / legal guardian is unavailable to give his / her permission for treatment, the participant and others whose signatures are attached below do hereby give permission to authorize any emergency action necessary to ensure the safety of the child. The intention hereof being to grant authority to administer and perform all and singularly any examinations, pre-participation physical examinations, treatments, anesthetics, operations, and diagnostic procedures which may now, or during the course of this participant's care, be deemed advisable or necessary. This does not hold Memorial Day School financially responsible for any medical care given.

I specifically acknowledge that **Football, Soccer, and Wrestling** are **collision sports** that involve an even greater risk of injury than **contact sports: Basketball, Baseball, Cheerleading, Softball, and Volleyball** which involve greater risk of injury than **non-contact sports: Track & Field, Tennis, Cross Country, Rowing and Golf.**

PARTICIPANT'S SIGNATURE

DATE

PARENT / GUARDIAN SIGNATURE

DATE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

GENERAL DISCLOSURE

I hereby authorize medical personnel to release information from my medical records for the purpose of payment, treatment or operations to their business associate partner which includes: the attending school's coaching staff and administrators; and any hospital in case of an emergency situation. This authorization shall be valid for the duration of the school year. It is subject to revocation by the patient, or the parent / guardian at any time except to the extent that action has been taken in reliance thereon. I am aware that once Memorial Day School discloses this information per my instructions, the information is subject to re-disclosure and may no longer be protected by the HIPAA (Health Insurance Portability and Accountability Act) of 1996. I understand that a photocopy of this authorization shall be as valid as the original. I know that I, or my authorized representative may receive a copy of this authorization upon request.

PARTICIPANT'S SIGNATURE

DATE

PARENT / GUARDIAN SIGNATURE

DATE

*If the athlete is **physically** unable to sign, please indicate such and identify the authority of the person to act who is signing for the athlete:* _____

DISCLOSURE REQUIRING SPECIAL CONSENT

My signature below specifically authorizes the release of health care information relating to the testing, diagnosis, or treatment for (please check all that you wish released):

_____ HIV / AIDS Virus

_____ Mental Health / Psychiatric Disorders

_____ Sexually Transmitted Diseases

_____ Drug / Alcohol Abuse / Treatment

If treatment is rendered for HIV / AIDS, Hepatitis, Psychiatric and / or alcohol / drug abuse, this release will be restricted to a one-time release of information only:

PARTICIPANT'S SIGNATURE

DATE

PARENT / GUARDIAN SIGNATURE

DATE

*If the athlete is **physically** unable to sign, please indicate such and identify the authority of the person to act who is signing for the athlete:* _____

PREPARTICIPATION PHYSICAL EVALUATION <> HISTORY FORM

DATE OF EXAM: ____ / ____ / ____

NAME: _____ SEX: _____ AGE: _____ DATE OF BIRTH: ____ / ____ / ____

GRADE: _____ SPORTS: _____

ADDRESS: _____ PHONE: (____) _____

PERSONAL PHYSICIAN: _____

In case of emergency, contact:

NAME: _____ RELATIONSHIP: _____ PHONE: (____) _____

	YES	NO		YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever told you that you have (check all that apply):	<input type="checkbox"/>	<input type="checkbox"/>	32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High blood pressure			33. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High cholesterol			34. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> A heart murmur			35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> A heart infection			36. Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	37. When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	42. Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	43. Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If "YES", circle below:	<input type="checkbox"/>	<input type="checkbox"/>	44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>

18. Have you had any broken or fractured bones or dislocated joints? If "YES", circle below:

HEAD	NECK	SHOULDER	UPPER ARM	ELBOW	FOREARM	HAND / FINGERS	CHEST
UPPER BACK	LOWER BACK	HIP	THIGH	KNEE	CALF / SHIN	ANKLE	FOOT / TOES

19. Have you had a bone or joint injury that required x-rays, surgery, injections, rehabilitation, physical therapy, a cast, MRI, CT, a brace, or crutches? If "YES", circle below:

HEAD	NECK	SHOULDER	UPPER ARM	ELBOW	FOREARM	HAND / FINGERS	CHEST
UPPER BACK	LOWER BACK	HIP	THIGH	KNEE	CALF / SHIN	ANKLE	FOOT / TOES

20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>
23. Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>	27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>

FEMALES ONLY

47. Have you ever had a menstrual period? YES NO

48. How old were you when you had your 1st menstrual period? _____

49. How many periods have you had in the last 12 months? _____

EXPLAIN "YES" ANSWERS HERE:

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

Signature of Athlete _____ DATE: _____

Signature of Parent / Guardian _____ DATE: _____

PREPARTICIPATION PHYSICAL EVALUATION <> PHYSICAL EXAMINATION FORM

To be completed by a physician

NAME: _____ DATE OF BIRTH: ____/____/____

HEIGHT: ____ft. ____ inches WEIGHT: _____ lbs. % BODY FAT (optional) _____ %

PULSE: _____ BP _____ / _____ (_____ / _____, _____ / _____)

VISION: R 20 / _____ L 20 / _____ CORRECTED: Y N PUPILS: Equal ____ Unequal ____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes / Ears / Nose / Throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)			
Skin			

MUSCULOSKELETAL

Neck			
Back			
Shoulder / Arm			
Elbow / Forearm			
Wrist / Hand / Fingers			
Hip / Thigh			
Knee			
Leg / Ankle			
Foot / Toes			

NOTES: _____

NAME OF PHYSICIAN (print or type): _____

ADDRESS: _____ PHONE: _____

SIGNATURE: _____ DATE: _____

MD or DO

PREPARTICIPATION PHYSICAL EVALUATION <> CLEARANCE FORM

NAME: _____ SEX: _____ AGE: _____

DATE OF BIRTH: ____/____/____

Cleared without restriction

Cleared, with recommendations for further evaluation or treatment for: _____

NOT CLEARED FOR:

All Sports

Certain Sports: _____

REASON: _____

RECOMMENDATIONS: _____

EMERGENCY INFORMATION:

Allergies: _____

Other Information: _____

Immunizations (e.g.: tetanus / diphtheria; measles; mumps; rubella; hepatitis A,B; influenza; poliomyelitis; pneumococcal; meningoccal; varicella)

UP TO DATE (see attached documentation)

NOT UP TO DATE

Specify: _____

NAME OF PHYSICIAN (print or type): _____

ADDRESS: _____ PHONE: _____

SIGNATURE: _____ DATE: _____

MD or DO

APPENDIX A

CONCUSSION INFORMATION FOR STUDENT ATHLETES

NAME OF SCHOOL: MEMORIAL DAY SCHOOL, SAVANNAH, GEORGIA

According to the article "Concussion" by the Mayo Clinic Staff, a concussion is defined and has symptoms as follows:

Definition:

A concussion is a traumatic brain injury that alters the way your brain functions. Effects are usually temporary, but can include problems with headache, concentration, memory, judgment balance and coordination. Although concussions usually are caused by a blow to the head, they can also occur when the head and upper body are violently shaken. These injuries can cause a loss of consciousness, but most concussions do not. Because of this, some people have concussions and don't realize it.

Concussions are common, particularly if you play a contact sport, such as football. But every concussion injures your brain to some extent. This injury needs time and rest to heal properly. Luckily, most concussive traumatic brain injuries are mild, and people usually recover fully.

Symptoms:

The signs and symptoms of a concussion can be subtle and may not be immediately apparent. Symptoms can last for days, weeks or even longer.

The most common symptoms after a concussive traumatic brain injury are headache, amnesia and confusion. The amnesia, which may or may not be preceded by a loss of consciousness, almost always involves the loss of memory of the impact that caused the concussion.

Signs and symptoms may include: * Headache or a feeling of pressure in the head * Temporary loss of consciousness * Confusion or feeling as if in a fog

- * Amnesia surrounding the traumatic event
- * Dizziness or "seeing stars"
- * Ringing in the ears
- * Nausea or vomiting
- * Slurred speech
- * Fatigue

The well-being of its Student Athletes is of paramount importance to the School. Coaches are trained annually in recognizing the signs and symptoms of concussions and are required immediately to remove from practice, conditioning, or a game any Student Athlete who shows such signs. Student Athletes will not be permitted to return until a Health Care Provider has either ruled out a concussion or determines the Student Athlete capable of returning. In no instance will a Student Athlete with a diagnosed concussion return the same day.

PRINTED Student Name: _____

Signature of Student: _____ Date: _____

PRINTED Parent Name: _____

Signature of Parent: _____ Date: _____

<http://www.mayoclinic.com/health/concussion/DS00320>.

**GEORGIA INDEPENDENT SCHOOL ASSOCIATION
CONCUSSION MANAGEMENT AND RETURN TO PLAY POLICY**

All Georgia Independent School Association Interscholastic Member Schools are required to comply with the following policy effective September 1, 2013. This policy applies to all practices, conditioning, and games in all sports. This policy will be reviewed by the Board of Trustees yearly, at which time comments and suggestions for the improvement of the policy will be solicited from all Member Schools, coaches, trainers, and officials, and appropriate modifications made.

I. Definitions.

- A. "Health Care Provider" means a licensed physician 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.
- B. "Student Athlete" means any student who participates in interscholastic athletic competitions at a Member School regardless of age.
- C. "Coach" means all coaches of all interscholastic sports whether full or part time and whether paid or volunteer.
- D. "Member School" means each Georgia Independent School Association Interscholastic Member School.

II. Policy.

- A. At the beginning of every school year, all Member Schools shall provide to the parents or legal guardians of every Student Athlete an information sheet which informs them of the nature and risks of concussions and head injuries and the actions to be taken by the schools to minimize the risks and effects of concussions and head injuries. Such information sheet should be substantially in the form of Appendix A to this Policy, and each Member School shall maintain a copy of the information sheet signed by each Student Athlete's parents or legal guardians for that school year.
- B. If a Coach observes a Student Athlete exhibit any sign, symptom, or behavior consistent with a concussion or head injury, the Coach must immediately remove that Student Athlete from practice, conditioning, or game. The Student Athlete may not return to practice, conditioning, or game until a Health Care Provider has determined that the Student Athlete has not suffered a concussion. In the case where a Health Care Provider has determined that the Student Athlete has suffered a concussion, the Student Athlete may not resume practice, conditioning, or participation in games until medically determined capable of doing so for full or graduated return. In no circumstance may a Student Athlete return to a practice, conditioning or a game on the same day that a concussion has been diagnosed by a Health Care Provider or cannot be ruled out.
- C. All Coaches must participate every year in a course of concussion management approved by the GISA. All Member Schools must maintain record of each Coach's participation in the course. The on-line course in concussion management entitled "Concussion in Sports" and prepared by National Federation of High School Sports Associations is acceptable and is available free to Member Schools at www.nfhslearn.com.

III. Penalties.

Member Schools violating this policy shall be fined a minimum of \$500.00 and a maximum of \$1,000.00 for the first offense. A Member School may be removed from membership for repeat violations.