

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

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

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth: _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (check box next to appropriate number)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	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)

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

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

Explain "Yes" answers here.

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

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2023 This form has been modified for use by the GHSA

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ (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) 		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> Pupils equal Hearing 		
Lymph nodes		
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis 		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional <ul style="list-style-type: none"> Double-leg squat test, single-leg squat test, and box drop or step drop test 		

^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: _____

Athletic Participation/Permission Form

I, the undersigned, am the parent/legal guardian of _____
(Student-Athlete Name - please print)
a minor and student-athlete at _____ who plans on
(Name of School)
participating in _____
(Sport(s))

I, hereby give consent for a Certified Athletic Trainer, Certified Nurse Practitioner, Certified Physician Assistant or Physician, an employee of St. Francis Physician Practices, LLC ("Practice Personnel") who is contracted by the School, to provide sports medicine and/or athletic training services for the above referenced Student-Athlete. Sports medicine athletic training services include, but are not limited to: administrating first aide for athletic injuries; providing initial treatment and management of acute injuries; and assessing athletic injuries at the request of the athlete, the athlete's coach, or the athlete's parent/guardian. The Practice Personnel will perform only those services that are within their training and scope of professional practice to prevent, care for, and rehabilitate athletic injuries of the Student- Athlete. I understand that as a result of the medical evaluation provided by the Practice Personnel, the Student-Athlete may be transported to a hospital emergency department for further treatment.

I understand that there is no charge to me for the above listed athletic training services. If the Student-Athlete is in need of further treatment by a physician, or of rehabilitation services for the injury, he or she may see the physician or provider of his/her choice. Injured Student-Athletes that have seen a physician **must submit** written clearance from that physician to the School and/or Practice Personnel prior to being permitted to resume athletic activity. This Authorization shall remain in effect for one sports season beginning with the date set forth below.

Parent/Guardian Name (Print) - _____
Parent/Guardian (Signature) _____ Date _____
Student-Athlete's Emergency Contact _____
Relationship to student athlete _____ Cell/Work phone _____
Home Address _____ Home phone _____
Student Athlete Name _____ Sex _____
Student Athlete Date of Birth _____ Allergies _____
Current Medications (i.e. asthma inhalers, epi-pen, etc.) _____
Physical impairments _____
Other pertinent medical history (surgeries, diabetes, seizures, heart condition, etc.) _____

Grade _____
Physician Name _____
Physician Phone _____

The Bradley Center of St. Francis, St. Francis Cardiothoracic and Vascular Institute, St. Francis Chattahoochee Valley Cardiology, St. Francis Center for Digestive Disorders, St. Francis Center for Surgical Care, St. Francis Columbus Clinic, St. Francis Columbus Specialty Clinic, St. Francis Electrophysiology Group, St. Francis ENT, St. Francis GYN Oncology, St. Francis Interventional Pain Management, St. Francis Neurology, St. Francis OBGYN Associates, St. Francis OBGYN Physician Partners, St. Francis Orthopaedic Institute, St. Francis Psychiatrists, Center, St. Francis Urgent Care-Midtown, St. Francis Wellness Center, St. Francis Wound Care & Hyperbaric Center, St. Francis Urology

Departments' of St. Francis Hospital

HIPAA ACKNOWLEDGEMENT AND FINANCIAL POLICY

NOTICE OF PRIVACY PRACTICES: Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

Patient
Initials

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

NAME	RELATIONSHIP	CONTACT NUMBER

ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION: I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S): Federal and state laws may permit this Clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates may be found in the Notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

EMAIL AND TEXT COMMUNICATIONS: If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Clinic, its affiliates, contractors, servicers, Clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

FINANCIAL POLICY: The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

- The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient-responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**
- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.
- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT

REQUESTS: If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgement and Financial Policy. I further acknowledge that I have been given the opportunity to ask questions.

Printed Name of Patient or Representative

Signature of Patient or Representative

Date

Relationship to Patient (if other than patient) _____

CLINIC STAFF USE ONLY

Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

The Bradley Center of St. Francis, St. Francis Cardiothoracic and Vascular Institute, St. Francis Chattahoochee Valley Cardiology, St. Francis Center for Digestive Disorders, St. Francis Center for Surgical Care, St. Francis Columbus Clinic, St. Francis Columbus Specialty Clinic, St. Francis Electrophysiology Group, St. Francis ENT, St. Francis GYN Oncology, St. Francis Interventional Pain Management, St. Francis Neurology, St. Francis OBGYN Associates, St. Francis OBGYN Physician Partners, St. Francis Orthopaedic Institute, St. Francis Psychiatrists, St. Francis Spine Center, St. Francis Urgent Care-Midtown, St. Francis Wellness Center, St. Francis Wound Care & Hyperbaric Center, St. Francis Urology

Departments' of St. Francis Hospital

PATIENT CONSENT

CONSENT FOR TREATMENT: I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

I acknowledge receipt of the Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

Printed Name of Patient or Representative

Signature of Patient or Representative

Date

Relationship to Patient (if other than patient) _____

CLINIC STAFF USE ONLY

Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

Witness (Staff) Signature

Witness (Staff) Printed Name

Date: _____



**GEORGIA INDEPENDENT ATHLETIC ASSOCIATION
STUDENT / PARENT SUDDEN CARDIAC ARREST AWARENESS FORM**

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.

LEARN TO RECOGNIZE SUDDEN CARDIAC ARREST

If you see someone collapse, assume they have 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). Call for help and start CPR. You cannot hurt them.

LEARN HANDS-ON 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 is 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, we give permission to the school to transfer this Form to all sports that this child may play. We are aware of the dangers of sudden cardiac arrest and this signed Sudden Cardiac Arrest Form will represent myself and this child during the current school year _____. This form will be stored with the Athlete’s Physical Form and any other accompanying forms required by the Georgia Independent Athletic Association (GIAA).

WE HAVE READ THIS FORM AND UNDERSTAND THE FACTS REPRESENTED IN IT.

SCHOOL NAME: _____

STUDENT’S NAME: _____ STUDENT’S SIGNATURE: _____
(PRINTED)

PARENT’S NAME: _____ PARENT’S SIGNATURE: _____
(PRINTED)

DATE SIGNED: _____



**GEORGIA INDEPENDENT ATHLETIC ASSOCIATION
STUDENT / PARENT CONCUSSION AWARENESS FORM**

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 GIAA 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.)

GIAA Concussion Policy: 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 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

By signing this Concussion Awareness Form, we give permission to the school to transfer this Form to all sports that this child may play. We are aware of the dangers of concussions and this signed Form will represent myself and this child during the current school year _____. This form will be stored with the Athlete's Physical Form and any other accompanying forms required by the Georgia Independent Athletic Association (GIAA).

WE HAVE READ THIS FORM AND UNDERSTAND THE FACTS REPRESENTED IN IT.

SCHOOL NAME: _____

STUDENT'S NAME: _____ STUDENT'S SIGNATURE: _____
(PRINTED)

PARENT'S NAME: _____ PARENT'S SIGNATURE: _____
(PRINTED)

DATE SIGNED: _____



GEORGIA INDEPENDENT ATHLETIC ASSOCIATION

HEAT POLICY AWARENESS FORM

Definitions:

- A. **"Practice"** means the period of time that a student engages in coach-supervised, school-approved preparation for sport whether indoors or outdoors, including Acclimation Activities, conditioning, weight training, distance running, and scrimmages, but not including a Walk Through.
- B. **"Walk Through"** means the period of time, not exceeding one hour per day, that a student engages in coach-supervised, school-approved sessions, whether indoors or outdoors, to work on formations, schemes, and techniques without physical contact. No protective equipment is worn during a Walk Through. No conditioning activities are held during a Walk Through. A Walk Through may not be held on a day when two practices are being held.
- C. **"Acclimation Activities"** in football means practicing in shorts, shoulder pads, and helmets for five consecutive weekdays prior to practicing in full pads. No contact will be allowed during this period. Starting Date for Acclimation is July 22.
- D. **"WBGT"** stands for the Wet Bulb Globe Temperature reading, which is a composite temperature used to estimate the effect of air temperature, humidity, and solar radiation on the human body, expressed in degrees. It is not equated with the "Heat Index."

Policy: All Member Schools will utilize at each Practice a scientifically approved instrument that measures WBGT. At the following WBGT readings the corresponding activity, hydration, and rest break guidelines apply:

Under 82.0

Normal activities. Provide at least three separate rest breaks each hour of a minimum duration of 3 minutes each during Practice.

82.0 - 86.9

Use discretion for intense or prolonged exercise. Watch at-risk students carefully. Provide at least three separate rest breaks each hour of a minimum of four-minute duration each during Practice.

87.0 - 89.9

Maximum outdoor Practice time is two hours. For football, students are restricted to helmets, shoulder pads, and shorts during Practice. All protective equipment must be removed for conditioning activities. For all sports, provide at least four separate rest breaks each hour of a minimum of four minutes each during Practice.

90.0 - 92.0

Maximum outdoor Practice time is one hour. No protective equipment may be worn during outdoor Practice and there may be no outdoor conditioning activities. There must be twenty minutes of rest breaks provided during the hour of outdoor Practice.

Over 92

No outdoor activities or exercise. Delay outdoor Practice until a lower WBGT reading occurs.

The following guidelines apply to **hydration and rest breaks**:

- Rest time should involve both unlimited hydrations (water or electrolyte drinks) and rest without any activity involved.
- For football, helmets should be removed during rest time.
- The site of the rest time should be a cooling zone not in direct sunlight, such as indoors, under a tent, or under a shade tree.
- When the WBGT is over 86, ice towels and spray bottles filled with ice water should be available in the cooling zone and cold immersion tubs will be available for a student showing signs of heat illness. A cold immersion tub may be anything, including a shower or wading pool that can be adapted to immerse a student in cold water and ice which is available within two-minutes travel from an outdoor Practice facility.

The following guidelines apply to **Practice**:

- All Member Schools must hold Acclimation Activities.
- No two-a-day Practices may exceed four hours for both sessions; no single Practice during two-a-days may exceed two hours. A three-hour rest period must be observed between the two sessions.
- No single Practice may last more than three hours.

Restrictions based on outdoor WBGT readings do not apply to indoor Practice where indoor air temperature is 85 degrees or less.

Penalties

Member Schools violating this policy will be fined a minimum of \$500 and a maximum of \$1,000 for the first offense. A Member School may be removed from membership for repeat violations.

By signing this Heat Policy Form, we give permission to the school to transfer this Form to all sports that this child may play. We are aware of the dangers of heat and this signed Form will represent myself and this child during the current school year _____. This form will be stored with the Athlete's Physical Form and any other accompanying forms required by the Georgia Independent Athletic Association (GIAA).

SCHOOL: _____

ATHLETIC DIRECTOR'S SIGNATURE: _____ DATE: _____

STUDENT ATHLETE'S SIGNATURE: _____ DATE: _____

PARENT'S SIGNATURE: _____ DATE: _____