Beaufort County School District
Athletic Parent Handbook
2019-2020
Acknowledgement Statement

By signing this statement, I acknowledge that I have read the **BCSD Athletic Guidelines** and agree to abide by the policies contained herein. I further understand that **BCSD** reserves the right to modify, amend or eliminate policies and procedures at any time. I further understand that policies in this handbook may be updated from time to time with or without prior notice. I acknowledge and agree that this **BCSD Athletic Guidelines** replaces all prior handbooks.

Parent Signature:  ________________________________
Date:  ________________________________
Students Signature:  ________________________________
Date:  ________________________________

A copy of this statement is signed and retained in the student-athletes athletic file.
<table>
<thead>
<tr>
<th>BEAUFORT COUNTY SCHOOLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019-2020 PARENT PERMISSION FOR INTERSCHOLASTIC ATHLETICS</td>
</tr>
<tr>
<td>Name of Parent/Guardian:</td>
</tr>
<tr>
<td>Student Name:</td>
</tr>
<tr>
<td>Street Address:</td>
</tr>
<tr>
<td>School:</td>
</tr>
<tr>
<td>City: State: Zip:</td>
</tr>
<tr>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Gender:</td>
</tr>
<tr>
<td>Parent/Custodian Phone:</td>
</tr>
<tr>
<td>Last School Attended:</td>
</tr>
<tr>
<td>Home:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Work:</td>
</tr>
<tr>
<td>Last Grade Completed:</td>
</tr>
<tr>
<td>Cell:</td>
</tr>
<tr>
<td>Email:</td>
</tr>
<tr>
<td>Emergency Contacts/Phone/Relationship to Student:</td>
</tr>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>Physician Information:</td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Telephone:</td>
</tr>
<tr>
<td>Hospital of Preference:</td>
</tr>
</tbody>
</table>

If your student attended a school outside the BCSD at the conclusion of the 2018-2019 school year, a grade report from that school must accompany this athletic packet.

**Request for Permission:** I, as the student’s parent/Guardian, would like to apply for permission for the above-named student to participate in interscholastic athletics in the following sports during the 2019-2020 school year:

- [ ] Basketball
- [ ] Golf
- [ ] Tennis
- [ ] Lacrosse
- [ ] Baseball
- [ ] Soccer
- [ ] Track
- [ ] Cheer
- [ ] Cross Country
- [ ] Softball
- [ ] Volleyball
- [ ] Dance
- [ ] Football
- [ ] Swimming
- [ ] Wrestling
- [ ] Field Hockey
HISTORY FORM
(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Name ____________________________ Date of birth ____________________________

Sex _______ Age _______ Grade _______ School _______ Sport(s) _______

Do you have any allergies?  □ Yes □ No
If yes, please identify specific allergy below.

□ Medicines □ Polens □ Food □ stingling Insects

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

----------------------------------------------------------------------------------------------------------------------

Explain “Yes” answers below. Circle questions you don’t know the answers to.

GENERAL QUESTIONS  Yes No
1. Has a doctor ever denied or restricted your participation in sports for any reason?
2. Do you have any ongoing medical conditions? If so, please identify below:
   □ Asthma □ Anemia □ Diabetes □ Infections Other: ____________
3. Have you ever spent the night in the hospital?
4. Have you ever had surgery?

HEART HEALTH QUESTIONS ABOUT YOU  Yes No
5. Have you ever passed out or nearly passed out during or after exercise?
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?
7. Does your heart race or skip beats (irregular beats) during exercise?
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:
   □ High blood pressure □ A heart murmur
   □ High cholesterol □ A heart infection
   □ Kawasaki disease □ Other: ____________________________
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)
10. Do you get lightheaded or feel more short of breath than expected during exercise?
11. Have you ever had an unexplained seizure?
12. Do you get more tired or short of breath more quickly than your friends during exercise?

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY  Yes No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?

BONE AND JOINT QUESTIONS  Yes No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?
18. Have you ever had any broken or fractured bones or dislocated joints?
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or clutches?
20. Have you ever had a stress fracture?
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)
22. Do you regularly use a brace, orthotics, or other assistive device?
23. Do you have a bone, muscle, or joint injury that bothers you?
24. Do any of your joints become painful, swollen, feel warm, or look red?
25. Do you have any history of juvenile arthritis or connective tissue disease?

MEDICAL QUESTIONS  Yes No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?
27. Have you ever used an inhaler or taken asthma medicine?
28. Is there anyone in your family who has asthma?
29. Were you born without or are you missing a kidney, an eye, a testicle (male), your spleen, or any other organ?
30. Do you have groin pain or a painful bulge or hernia in the groin area?
31. Have you had infectious mononucleosis (mono) within the last month?
32. Do you have any rashes, pressure sores, or other skin problems?
33. Have you had a herpes or MRSA skin infection?
34. Have you ever had a head injury or concussion?
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
36. Do you have a history of seizure disorder?
37. Do you have headaches with exercise?
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
39. Have you ever been unable to move your arms or legs after being hit or falling?
40. Have you ever become ill while exercising in the heat?
41. Do you get frequent muscle cramps when exercising?
42. Do you or someone in your family have sickle cell trait or disease?
43. Have you had any problems with your eyes or vision?
44. Have you had any eye injuries?
45. Do you wear glasses or contact lenses?
46. Do you wear protective eyewear, such as goggles or a face shield?
47. Do you worry about your weight?
48. Are you trying to or has anyone recommended that you gain or lose weight?
49. Are you on a special diet or do you avoid certain types of foods?
50. Have you ever had an eating disorder?
51. Do you have any concerns that you would like to discuss with a doctor?

FEMALES ONLY
32. Have you ever had a menstrual period?
33. How old were you when you had your first menstrual period?
34. How many periods have you had in the last 12 months?

Explain “yes” answers here

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

Signature of athlete: ____________________________ Date: ____________________________

Signature of Parent/Guardian: ____________________________ Date: ____________________________
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, 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 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 (questions 5–14).

<table>
<thead>
<tr>
<th>EXAMINATION</th>
<th>Height</th>
<th>Weight</th>
<th>□ Male □ Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>SP</td>
<td>/</td>
<td>/</td>
<td></td>
</tr>
<tr>
<td>Pulse</td>
<td></td>
<td>Vision R20/</td>
<td>L 20/ Corrected □ Y □ N</td>
</tr>
</tbody>
</table>

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

Appearance
- Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperflexity, myopia, MVP, aortic insufficiency)

Eyes/ears/nose/throat
- Pupils equal
- Hearing

Lymph nodes

Heart *
- Murmurs (auscultation standing, supine, +/- Valsalva)
- Location of point of maximal impulse (PMI)

Pulses
- Simultaneous femoral and radial pulses

Lungs
Abdomen
Genitourinary (males only)?
Skin
- HSV, lesions suggestive of MRSA, tinea corporis

Neurologic *

MUSCULOSKELETAL

Neck
Back
Shoulder/arm
Elbow/forearm
Wrist/hand/fingers
Hip/-thigh
Knee
Leg/ankle
Foot/toes
Functional
  • Duck-walk, single leg hop

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
*Consider GU exam if in private setting. Having third party present is recommended.
*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction
☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for:
   ____________________________
☐ Not cleared
   o Pending further evaluation
   o For any sports
   o For certain sports

Reason: __________________________________________

Recommendations: __________________________________________

I have examined the above-named student and completed the pre-participation physical examination. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical examination is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) __________________________ Date __________________________

Address __________________________________________ Phone __________________________

Signature of physician __________________________________________ MD or DO
PARENT ACKNOWLEDGEMENT

Parent Acknowledgement of Risk: As a parent/Guardian of the above named student-athlete, I give permission for his/her to participate in athletic events and the physical evaluation for participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment recommended by a medical professional. I grant permission to nurses, trainers and coaches, as well as physicians or those under their direction who are a part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that, to the best of my knowledge, my answers to the above questions are complete and correct. I understand the data acquired during these evaluations may be used for research purposes.

Parent Pledge: As a parent, I understand that I am a role model. My signature below indicates my agreement to each of the following: I will remember that school athletics are an extension of the classroom, offering learning experiences for students, whether participating or spectating. I will show respect for the opposing teams involved. Using inappropriate language and taunting are contrary to the spirit of fair play and good sportsmanship that the BCSD, its schools, the athletic conferences in which our schools participate and the SCHSL expects of its members. I accept my responsibility to model good sportsmanship that comes with being the parent of a student-athlete. I agree to encourage and support my student by attending parent meetings as required by the school/coach. Lending support to the school/activity booster club, ensuring that my student follows all SCHSL, BCSD, school, and team conduct, rules, interacting with classroom teachers, counselors, and school administrators on a regular basis to monitor the academic success/progress of my student, demonstrating good sportsmanship at all times towards coaches, officials, competitors, and personnel, submitting all fees and forms as required for participation, following the established methods to address program/individual concerns by first contacting my student’s coach, attending contests in which my students will be involved as often as possible, and ensuring my student has the necessary transportation to/from practices and events.

Student Name: (PRINT): ____________________________________________
Student Signature:_________________________________ Date: ________________

Parent/Guardian (PRINT): __________________________________________
Parent/Guardian Signature:________________________________ Date: ________________
PARENTAL PERMISSION AGREEMENT FORM

School: __________________________________ Activity: ______________________________

Student Name: ____________________________ Grade: ______________________________

As the parent/guardian of a Beaufort County School District student, choosing to participate in co-curricular activities, I agree to encourage and support my son/daughter and his/her activity by:

1. Attending parent meetings as required by the school/coach
2. Lending support to the school/activity Booster Club
3. Ensure that my son/daughter follows all state, district, student code of conduct and all discipline codes at all times
4. Interacting with classroom teachers, counselors, and school administration on a regular basis to monitor the academic success/progress of my student
5. Demonstrating good sportsmanship at all times towards coaches, officials, home team/visitors, competitors and personnel
6. Submitting all fees and forms as required for participants
7. Following the established methods to address program/individual concerns by making the initial contact for a scheduled conference by using the Chain of Command:
   - A. Assistant Coach
   - B. Head Coach
   - C. Athletic Director
   - D. Assistant Principal
   - E. Principal
   - F. District Office
8. Attending contest in which my student will be involved as much as possible
9. Ensuring my student has the necessary transportation to/from practices and events

As a parent/guardian, I understand that my direct involvement and support is necessary in order for this to be a valuable experience for my son/daughter. My signature below indicates that I have agreed to the above terms of this agreement.

Parent/Guardian (PRINT): ____________________________

Parent/Guardian Signature: ____________________________ Date: ____________________
DRUG TESTING CONSENT FORM

I desire________________________________________, (student) be able to participate in some or all of the following voluntary activities or privileges offered by the Beaufort County School District which includes: interscholastic athletics, other voluntary extra-curricular activities, and campus parking privileges.

I hereby agree that:

☐ I have read and understand the Beaufort County School District’s administrative regulation governing random student drug testing

☐ _______________________________________, (student) shall be enrolled in the Beaufort County School District random drug testing program beginning with this school year and may be drug-tested in accordance with the random drug testing regulation at any time during his/her enrollment in the Beaufort County School District.

☐ Drug test of student under the random drug testing regulation are completely voluntary and a student is never forced to undergo a drug test. However, a refusal to take a drug test shall result in the same consequences as a positive drug test.

☐ Drug test results may be released to the student, parent/guardian, the contracted Test Administrator for the Beaufort County School District, Medical Review Officer, Superintendent designee and the student’s School Principal.

________________________________________  __________________________________
Name of Student (PRINT)          Name of Parent/Guardian

________________________________________  __________________________________
Signature of Student          Signature of Parent/Guardian

Dated: _______________________, 20___
STUDENT – ATHLETE CONCUSSION ACKNOWLEDGEMENT STATEMENT

I, ______________________________, understand that it is my responsibility to report all injuries and illnesses, including concussions, to my athletic trainer and/or head coach.

I have read and understand the CDC concussion fact sheet, *A Concussion Fact Sheet for Athletes*, and am aware of the following information:

1. A concussion is a brain injury, which I am responsible for reporting to the head coach or athletic trainer.
2. A concussion can affect my ability to perform everyday activities and affect reaction time, balance, sleep, and classroom performance.
3. I cannot see a concussion, but I might notice some of the symptoms right away. I understand other symptoms can show up hours or days after the injury.
4. If I suspect a teammate has a concussion, I am responsible for reporting the injury to my head coach or athletic trainer.
5. I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion-related symptoms.
6. Following concussion, I understand that the brain needs time to heal. I understand that I am much more likely to have a repeat concussion if I return to play before symptoms resolve.
7. In rare cases, I realize repeat concussions can cause permanent brain damage and even death.

I acknowledge that I have read and understand the CDC’s *A Fact Sheet for Athletes* and the Beaufort County Student Athlete Insurance Coverage policy and accept these responsibilities to protect my well-being. If I have any questions, it is my responsibility to ask the athletic training staff or my coach.

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of Parent/Guardian:</th>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>