

Dear Parents,

Through state law, GCAA requirements, church policy, school standards, and a general concern for the welfare of the students involved, we have adopted a set of requirements that must be met before a student may participate in the athletic program at Byne Christian School. Below, you will find a list of these requirements along with a brief explanation, if necessary. You should find all relevant forms enclosed in this packet. If you find that any are missing, please contact the school office for a replacement.

Homeschool Sports Registration Packet Contents

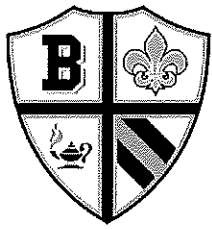
- 1.) Homeschool Sports Application Form
(Please complete and return to School Office before 1st practice.)
- 2.) Sports Physical Forms
(Take Physical Forms to your child's doctor for completion. Return completed forms to School Office before tryouts.)
- 3.) GCAA Waiver
(Please complete and return to School Office before 1st practice.)
- 4.) Concussion Information Sheet
(Read and sign form. Return completed form to School Office before 1st practice.)
- 5.) Byne Waiver
(Please complete and return to School Office before 1st practice.)
- 6.) Medical Release Form
(Please complete and return to School Office before 1st practice.)
- 7.) Athletic Handbook
(Print off Byne website and keep for your records)

Before your child can participate in Byne Sports practice or games, the School Office must receive the following items:

- *All completed forms from this packet.*
 - *A copy of your child's birth certificate.*
 - *A copy of your child's current health insurance card.*
 - *A copy of your child's class schedule (Please include relevant curriculum information, such as textbooks used.)*
 - *Registration Fee of \$200 (Must pay prior to first practice)*
 - *Please have all of these items before bringing them to the school office.*
-

Thank you for your cooperation in meeting these requirements. If you have any questions, feel free to contact me through email at qsanders@bccsaints.org or you can set up an appointment to meet in person or over the phone by calling the school office at 229-436-0173.

Sincerely,
Quinten Sanders
Athletic Director, Byne Christian School



BYNE
CHRISTIAN SCHOOL
EST. 1983

**HOME SCHOOL SPORTS
APPLICATION FORM
2021-2022**

Father's Work #: _____

Father's Cell #: _____

Father's Email: _____
(Please print clearly)

Mother's Work #: _____

Mother's Cell #: _____

Mother's Email: _____
(Please print clearly)

Grade Level: _____

Check sport you are registering child for:

Baseball Basketball Softball Volleyball

Full Name of Child: _____

Birth Date: Month _____ Day _____ Year _____ Age: _____ Sex: M F (circle one)

Residence of Child: Street Address _____

City _____ State _____ Zip Code: _____ County _____

Home Telephone: _____

Pupil lives with: Both Parents Father Mother Guardian Grandparents

Father's Name: _____ Marital Status: _____

Address (if different from above) _____

Employment: _____ Telephone: _____
(Company) (Address)

Mother's Name: _____ Marital Status: _____

Address (if different from above) _____

Employment: _____ Telephone: _____
(Company) (Address)

Whom may we contact, other than parents, in the event of an emergency?

Name: _____ (Relationship) _____

Phone: _____ (Home) _____ (Work) _____ (Cell)

In the event of an extreme emergency and you can not be reached, may we contact the medical emergency personnel? Yes No Hospital Preferred: _____

Who has permission to pick up your child other than parents/guardian? _____

Where did your child last attend school? _____

Church/Affiliation/Name of Church: _____

Please complete the back of this application form.

Preparticipation Physical Evaluation

HISTORY FORM

Date of Exam _____

Name _____ Sex _____ Age _____ Date of birth _____
 Grade _____ School _____ Sport(s) _____
 Address _____ Phone _____
 Personal Physician _____
In case of emergency, contact:
 Name _____ Relationship _____ Phone (H) _____ Phone (W) _____

**Explain "Yes" answers below.
 Circle questions you don't know the answers to.**

- | | 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): | | | 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 tendonitis, that caused you to miss a practice or game? If yes, circle affected area 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: | <input type="checkbox"/> | <input type="checkbox"/> | 45. Do you limit or carefully control what you eat? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 19. Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/> | 46. Do you have any concerns that you would like to discuss with a doctor? | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 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"/> | 47. Have you ever had a menstrual period? | <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"/> | 48. How old were you when you had your first menstrual period? _____ | | | | |
| 22. Do you regularly use a brace or assistive device? | <input type="checkbox"/> | <input type="checkbox"/> | 49. How many periods have you had in the last 12 months? _____ | | | | |
| 23. Has a doctor ever told you that you have asthma or allergies? | <input type="checkbox"/> | <input type="checkbox"/> | 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 _____ Signature of Parent/Guardian _____ Date _____

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name _____ Date of Birth _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP ____ / ____ (____ / ____, ____ / ____)

Vision R 20/____ L 20/____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
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			

*Multiple-examiner set-up only.
 +Having a third party present is recommended for the genitourinary examination.

Notes: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, 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 _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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Preparticipation Physical Evaluation

CLEARANCE FORM

Name _____ Sex _____ Age _____ Date of birth _____

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Not Cleared for All sports Certain sports: _____ Reason: _____

Recommendations: _____

EMERGENCY INFORMATION

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Other Information _____

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Address _____ Phone _____

Signature of physician _____, MD or DO

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GEORGIA CHRISTIAN ATHLETIC ASSOCIATION

(Athletic Division of the Georgia Association of Christian Schools)

Liability Waiver Form

This Liability Waiver Form must be completed, and signed by the parent or guardian for each student athlete (including cheerleaders) before participation in any GCAA athletic practice, game, activity, contest or event. The original must be on file in the school office.

PARENT/GUARDIAN RELEASE

FOR AND IN CONSIDERATION OF the mutual promises, covenants, conditions, representations, and warranties contained herein, and for other good and valuable consideration, the receipt and legal sufficiency of which are hereby acknowledged, it is agreed as follows:

The undersigned hereby releases and forever discharges the Georgia Association of Christian Schools (GACS) and its athletic division known as the Georgia Christian Athletic Association (GCAA), along with all of its agents, employees, directors, officers, assigns, and attorneys, from any and all claims, demands, actions, causes of action or suits arising out of any injuries, known or unknown, which have resulted or may in the future result from any GACS/GCAA sponsored athletic game, activity, contest or event.

The undersigned hereby assumes all risk of injury associated with any such athletic game, activity, contest or event and fully indemnifies and holds harmless the GACS and GCAA along with its agents, employees, directors, officers, assigns, and attorneys from and against each and every liability, loss, cost, damage, and expense, including attorney's fees, which the GACS and GCAA along with its agents, employees, directors, officers, assigns, and attorneys may incur as a result of any GACS/GCAA sponsored athletic game, activity, contest or event.

This liability waiver/release applies to the following student athlete:

STUDENT'S NAME: _____
First Middle Last

who is currently enrolled in the following GACS/GCAA member school:

SCHOOL NAME: Byne Christian School

SCHOOL ADDRESS: 2832 Ledo Road Albany GA 31707
Street City State ZIP

This _____ day of _____ 20_____.

 Parent/Guardian's Signature

 Parent/Guardian's Printed Name

Concussions

What you need to know



What is the law?

Schools: House Bill 284, the Return to Play Act of 2013, requires all public and private schools to create a concussion policy that, at a minimum, includes these standards:

- Prior to the beginning of each athletic season, an information sheet that informs parents or legal guardians of the risk of concussions must be provided.
- If a youth athlete (ages 7 to 18) participating in a youth athletic activity exhibits signs or symptoms of a concussion, he must be removed from play and evaluated by a healthcare provider.
- Before a youth athlete can return to play, he must be cleared by a healthcare provider trained in the management of concussions.

Recreational Leagues: HB 284 requires recreational leagues to provide an information sheet on the risks of concussion at the time of registration to all youth athletes' (ages 7 to 18) parents or legal guardians.

What is a concussion?

It is a type of brain injury caused by trauma. It can be caused by a hard bump on or blow to or around the head, which causes the brain to move quickly inside the head. You do not have to lose consciousness to have a concussion. If a concussion is not properly treated, it can make symptoms last longer and delay recovery. A second head trauma before recovery could lead to more serious injuries.

What are the signs and symptoms?

There are many signs and symptoms linked with concussion. Your child may not have any symptoms until a few days after the injury. Signs are conditions observed by other people and symptoms are feelings reported by the athlete.

Signs observed by others

- Appears dazed or stunned
- Moves clumsily
- Forgets plays
- Answers questions slowly
- Is unsure of game or opponent
- Shows behavior or personality changes

Symptoms reported by athlete

- Headache
- Fuzzy vision
- Nausea
- Feeling foggy
- Dizziness
- Concentration problems

For a full list of signs and symptoms visit choa.org/concussion.

What should you do if you suspect a concussion?*

- Do not let your child play with a head injury.
- Check on your child often after the injury for new or worsening signs or symptoms. If the symptoms are getting worse, take him to the nearest Emergency Department.
- Take your child to the doctor for any symptom of a concussion.
- Do not give your child pain medications without talking to your child's doctor.
- Your child should stop all athletic activity until his doctor says it is OK. Your child must stay out of play until he is cleared by a licensed healthcare provider.
- Educate your child on concussions and why he cannot play until the symptoms are gone. Your child will need a gradual return to school and activities.
- Tell your child's coaches, school nurses and teachers if he has a concussion.

**In case of an urgent concern or emergency, call 911 or go to the nearest emergency department right away.*

Warning signs

Call your child's doctor right away if he has:

- New signs that his doctor does not know about
- Existing signs that get worse
- Headaches that get worse
- A seizure
- Neck pain
- Tiredness or is hard to wake
- Continued vomiting
- Weakness in the arms or legs
- Trouble knowing people or places
- Slurred speech
- Loss of consciousness
- Blood or fluid coming from nose or ear
- A large bump or bruise on scalp, especially in infant younger than 12 months

Where can I find more information?

Visit choa.org/concussion for return to school and activities guidelines, educational videos and general concussion information.

This is general information and not specific medical advice. Always consult with a doctor or healthcare provider if you have questions or concerns about the health of a child. This piece was created by the concussion team at Children's Healthcare of Atlanta. ©2013 Children's Healthcare of Atlanta Inc. All rights reserved.

It is the policy of Byne Christian School that athletes cannot practice or compete in activities until this form is signed and returned. By signing this form, you acknowledge that you have received the fact sheet on concussions.

Athlete's Signature

Date

Athlete's Printed Name

Athlete's Parent/Guardian Signature

Date

Byne Christian School Medication Release Form

Student Name _____

Grade _____

Mother's Name _____

Phone# _____

Father's Name _____

Phone# _____

For your child's well-being, parents will be contacted before administering any of the following medications. All medications will be administered through the school office.

Please indicate yes or no (If yes, indicate dosage)

_____ Ibuprofen* Dosage appropriate for your child _____

_____ Tylenol* Dosage appropriate for your child _____

_____ Antacid (chewable only) Dosage appropriate for your child _____

_____ Cough Drops (only one administered per day)

*A chewable form and liquid form of these medications are available for the lower elementary only.

Emergency Medical Authorization

Should _____, _____, suffer an injury
(Student's Name) (Date of Birth)

or illness while at Byn Christian School or in a school vehicle and the school personnel is unable to contact me immediately, the school shall be authorized to secure such medical attention and care for my child as may be necessary. I agree to keep the school informed of changes in telephone numbers where I can be reached.

My child's primary source of healthcare is:

Physician or Clinic Name

Telephone Number

Known medical conditions (i.e.) diabetes, asthma, drug or food allergies:

Signature of parent

Date

Telephone Number