

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.

---

## **Secondary Sports Registration Packet Contents**

- 1.) Sports Physical Forms  
*(Take Physical Forms to your child's doctor for completion. Return completed forms to School Office prior to tryouts).*
- 2.) GCAA Waiver  
*(Please complete and return to School Office before 1<sup>st</sup> practice.)*
- 3.) Concussion Information Sheet  
*(Read and sign form. Return completed form to School Office before 1st practice.)*
- 4.) Byne Waiver  
*(Please complete and return to School Office before 1<sup>st</sup> practice.)*
- 5.) Medical Release Form  
*(Please complete and return to School Office before 1<sup>st</sup> practice.)*
- 6.) 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.***
  - ***Registration Fee of \$150***
- 

Thank you for your cooperation in meeting these requirements. If you have any questions, feel free to contact me through email [qsanders@bcssaints.org](mailto:qsanders@bcssaints.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

# 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 tendinitis, 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*
<b>MEDICAL</b>			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
<b>MUSCULOSKELETAL</b>			
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

© 2004 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

**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

© 2004 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

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

#### Symptoms reported by athlete

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

For a full list of signs and symptoms visit [choa.org/concussion](http://choa.org/concussion).

*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.*

### 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](http://choa.org/concussion) for return to school and activities guidelines, educational videos and general concussion information.

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 Byne 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