

Centennial Swimming and Diving Team 2011-2012 Contract

Swimmers Name: _____

As a member of the Centennial Swimming and Diving the following is expected behavior:

- Strive to improve at all times
- Support and encourage team members
- Strive toward top physical conditioning
- Exercise appropriate conduct in and out of the school
- Display good sportsmanship at all times with teammates and opponents
- Maintain high academic standing
- Do not use cigarettes, alcohol, and/or drugs

Pledge to do the following:

- Adhere to the Centennial High School Code of Conduct
- Participate in all practices (with the exception of days pre-arranged with coaches)
- *Please see handbook regarding practice agreement
- Participate in all meets unless pre-arranged with coaches
- Participate in all team functions unless pre-arranged in writing with coaches

I have along with my parent(s) reviewed the Swim and Dive Meet Schedule and I am available for all meets except these dates. (The dates and reason for absences will be reviewed by the coaching staff.)

Meets:	Reason for Absence:

By signing this contract both you and your parent(s) indicate that you are both prepared to accept the above guidelines and understand that not living up to these guidelines will prohibit you from receiving a letter award for your participation.

Swimmer \ Diver Signature

Date

Parent Signature

Date

Coach's Signature

Date

Centennial High School Swimming and Diving 2011-2012 Season

Name: _____

Swimmer's Email: _____

Address: _____

Swimmers Cell Phone: _____

Locker Number\Hall: _____

Parent Name(s): _____

Home Phone Number: _____

Additional Number: _____

Parent(s) Email Address: _____

Class: Freshman Sophomore Junior Senior

Swimmer or Diver (or both): _____

Member of a USS Team?

Name of Team: _____

Coach: _____

Team Jacket and Shirt Size: Small Medium Large X-Large

Do you participate in a fall sport: Yes\No If yes, which one: _____

1 st Period	Class	Teacher	Lunch	Class	Teacher
2 nd Period			5 th Period		
3 rd Period			6 th Period		
4 th Period			7 th Period		

**Centennial High School Swimming and Diving Team
Swimming Information Sheet
2011-2012**

First \ Last Name: _____

Year: _____

Swimming Experience:

Please fill in times for all events that you have participated in the past:

<i>Event:</i>	<i>Best Time:</i>	<i>Goal Time:</i>
50 Free		
100 Free		
200 Free		
500 Free		
100 Back		
100 Breast		
100 Fly		
200 IM		

- What events do you like swimming?
- What are your best events?
- What events do you dislike or cannot swim?
- Past swimmers, what events did you swim last year?

**Release of Liability for Students Transporting Themselves
Between School Sites During the School Day**

Effective for School Year 2011-2012

Parents/Guardians/Adult Students (over Age 18):

If your high school student (or you, if you are a student over age 18 or over) plans to drive himself or herself between school sites during the school day and/or to school-related events, activities, or sites after school hours, please complete and sign the following form, and return it to your school principal. Completing this form is not necessary for students from home to school and to home each day.

(Student's Name) _____ has my permission to drive to and from school sites during the school day and/or to school-related events, activities, or sites after school hours during the 2011-2012 school year, and/or ride with another student who is driving to and from school sites during the school day and/or to school-related events, activities, or sites after school hours during the same year.

I agree to hold Fulton County Board of Education harmless in the event of injury to this student, including any property damage while the student is driving or being driven to or from a school site and/or to school-related events, activities, or sites after school hours in a vehicle other than that provided by Fulton County Board of Education.

In addition, I agree not to assert against the Fulton County Board of Education, all current, former and future members of the School Board of the Fulton County Board of Education, former or future employees of the Fulton County Board of Education, and their heirs, executors, administrators, successors, and assigns, in any court of law, any claim or claims that the student and/or parent or legal guardian had, now have, or may have in the future, whether known or unknown, based on any injuries sustained by the student while being so transported.

I have read the above agreement, and voluntarily sign the release and waiver of liability, and further agree that no oral representations, statements or inducements apart from the foregoing written agreement have been made.

Signature of Parent,
Legal Guardian, or Adult Student: _____

Date: _____

(FOR SCHOOL USE ONLY)

Received by : _____ on _____
(print full name) (print date)

Signature of receiving party: _____

PRIOR TO PARTICIPATION IN ANY CONDITIONING, TRYOUT, PRACTICE SESSION, OR PLAY IN ANY INTERSCHOLASTIC ATHLETIC ACTIVITY, THE STUDENT-ATHLETE MUST SUBMIT THIS FORM TO THE COACH OF THE ACTIVITY. FAILURE TO SUBMIT THIS FORM WILL DELAY THE ELIGIBILITY OF THE STUDENT-ATHLETE TO JOIN THE TEAM.

**Release of Liability for Student-Athletes Being Transported by Fulton County Schools Bus Transportation
Or**

**By a Parent, Legal Guardian, or By Parent/Legal Guardian Designated Driver Between School Sites, Events, Activities During
and After the School Day Effective for School Year 2011-2012**

Fulton County School Bus Transportation Permission

Since your high school student will be transported by Fulton County bus transportation between school sites, events, activities during and after the school day, please complete and sign the following form, and return it to your coach.

Signature of Parent or Legal Guardian: _____ Date: _____

Signature of Student Athlete: _____ Date: _____

Designated Driver (if applicable): All designated drivers must be family relative over 18 years of age or a parent / legal guardian of another student attending the school.

(Student's Name) _____ has my permission to be transported to and from school sites during the school day and/or to school-related events, activities, or sites after school hours as a participant on the _____ High School _____ Team. Either I or my designated driver (name of driver) _____ will be transporting the student to and/or from the event or activity. Either I or my designated driver will present himself or herself to the head coach and/or assistant coach after the event or activity has been completed in order to verify the intent to transport the above mentioned student.

I agree to hold Fulton County Board of Education harmless in the event of injury to this student, including any property damage while the student is driving or being driven to or from a school site and/or to school-related events, activities, or sites after school hours in a vehicle other than that provided by Fulton County Board of Education.

In addition, I agree not to assert against the Fulton County Board of Education, all current, former and future members of the School Board of the Fulton County Board of Education, former or future employees of the Fulton County Board of Education, and their heirs, executors, administrators, successors, and assigns, in any court of law, any claim or claims that the student and/or parent or legal guardian had, now have, or may have in the future, whether known or unknown, based on any injuries sustained by the student while being so transported.

I have read the above agreement, and voluntarily sign the release and waiver of liability, and further agree that no oral representations, statements or inducements apart from the foregoing written agreement have been made.

Signature of Parent or Legal Guardian: _____ Date: _____

Signature of Student Athlete: _____ Date: _____

Signature of Designated Driver: _____ Date: _____

(FOR SCHOOL USE ONLY)

Received by : _____ on _____
(print full name) (print date)

Signature of receiving party: _____

PRIOR TO PARTICIPATION IN ANY CONDITIONING, TRYOUT, PRACTICE SESSION, OR PLAY IN ANY INTERSCHOLASTIC ATHLETIC ACTIVITY, THE STUDENT-ATHLETE MUST SUBMIT THIS FORM TO THE COACH OF THE ACTIVITY. FAILURE TO SUBMIT THIS FORM WILL DELAY THE ELIGIBILITY OF THE STUDENT-ATHLETE TO JOIN THE TEAM.

**FULTON COUNTY SCHOOL SYSTEM DEPARTMENT OF ATHLETICS
STUDENT'S APPLICATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS
AND VERIFICATION OF INSURANCE**

Sport: _____ **Date of first practice:** _____, 2011/2012

Student Name: _____ **Male** _____ **or Female** _____
(Last name) (First name) (MI)

Date of Birth: _____ **Age:** _____ years old
(Month) (Day) (Year)

Address: _____
(# and Street Name) (City) (State) (Zip Code)

Home Telephone #: _____ **Emergency Telephone #** _____

This application to represent my school in interscholastic activities is entirely voluntary on my part and is made with the understanding that I have studied and understood the Eligibility Standards that I must meet to represent my school and that I have not violated any of these standards. I understand that meeting the citizenship standards set by the school or being ejected from an interscholastic contest because of an unsportsmanlike act, could result in my not being allowed to participate in the next contest or suspension from the team either temporarily or permanently. I understand that if I transfer to another school my eligibility may be affected under the Georgia High School Association's eligibility standards.

Student Signature: _____
(Signature) (School) (Date)

We hereby give our consent for the above student to represent his/her school in interscholastic activities. We have received a Student/Parent Handbook for GHSA Sanctioned Interscholastic Activities. We understand that we are responsible for reading the contents of this publication and that questions related to this publication can be addressed to the Fulton County Athletic Director at 404-763-6892. If we, the parent(s)/guardian(s), cannot be reached in the event of a medical emergency, we do give consent for the school to obtain emergency transportation to the physician or hospital of its choice, and such medical care as is reasonably necessary for the welfare of the student if he/she is injured in the course of participation in interscholastic activities. We give permission for our son/daughter to participate in school-sponsored trips, including overnight trips, associated with Fulton County School's interscholastic athletic competitions. In the event that transportation is not provided by the Fulton County School System, transportation will be the student's or the parent's /Guardian's responsibility. I / We release and waive, and further, hold harmless or reimburse the Fulton County School System, the Board of Education, its successors and assigns, its members, agents, employees and representatives thereof, as well as trip-supervisors from and against, any claim which I, any other parent or guardian, the student, pr any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, from any losses, damages or injuries arising out of, during, or in conjunction with the student's participation in the activity, any trip, or transportation associated with the activity, or the rendering or emergency medical procedures or treatment, if any.

All parents and guardians must sign and date this form

Signature of parent/guardian: _____ **Date:** _____

Signature of parent/guardian: _____ **Date:** _____

PRIOR TO PARTICIPATION IN ANY CONDITIONING, TRYOUT, PRACTICE SESSION, OR PLAY IN ANY INTERSCHOLASTIC ATHLETIC ACTIVITY, THE STUDENT-ATHLETE MUST SUBMIT THIS FORM FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS TO THE COACH OF THE ACTIVITY. FAILURE TO SUBMIT THIS FORM WILL DELAY THE ELIGIBILITY OF THE STUDENT-ATHLETE TO JOIN THE TEAM.

**FULTON COUNTY SCHOOL SYSTEM DEPARTMENT OF ATHLETICS
VERIFICATION OF INSURANCE COVERAGE**

Effective for School Year 2011-2012

I have waived the medical/health insurance coverage that has been approved by the Fulton County School System and offered to my child, _____ . Date of Birth: _____
(Name of Child)

The medical/ health insurance that I am using for my child for the current school year at _____ is provided by _____ and _____
(School Name) (Name of Insurance Company)

the insurance policy number is _____. This insurance policy
(Insurance Policy Number)

is in effect from: _____ to _____.
(Date) (Date)

Attach a copy of Medical/Health Insurance Certificate to this form to verify information listed above. Thank you.

The above medical/health insurance coverage provides for the following interscholastic athletics activities:

1. _____
2. _____
3. _____
4. _____

We/I understand that per The Georgia High School Association a Pre-participation Physical evaluation must be performed by a physician to medically screen each student who participates in the interscholastic athletic programs of the Fulton County School District. We/I understand that a basic medical screening (the required physical exam) is general in nature and limited in scope and does not indicate or assure me/us that my/our child is completely free from impairments. If I/we wish for a more detailed physical exam to be performed upon my/our child then it is my/our responsibility to arrange and to pay for such an exam. If this more detailed exam is performed, it is my/our responsibility to notify the Fulton County School District, and its appropriate employees , of any potential medical problems uncovered by any physical exam given to my/our child other than the general physical required by the school system for athletic participation. I agree to fully waive any and all claims of whatever nature, fully and finally, now and forever, for my/our child, for myself, my estate, my heirs, my administrators, my executors, my assignees, my agents, my successors, and for all member of my family, and to indemnify, release, defend, exonerate, discharge and hold harmless the Fulton County School District, their schools, their trustees, officers, Board members, Board of Education, employees, agents, coaches, athletic trainers, physicians, and any other practitioner of the healing arts (an "Indemnified Party") from any and all liability, personal or property damages, claims, causes of action or demands brought against the Fulton County School District or indemnified party arising out of any injuries to my/our child or to his or her property or losses of any kind which may result from or in connection with his or her participation in any activity related to the interscholastic athletic programs provided by the Fulton County School District.

My signature below attests that I have read, understood and concur with the information on this form, and that I give consent for my child to participate in the athletic programs as stated above.

ALL PARENTS/GUARDIANS/ MUST SIGN BELOW AND DATE

Signature of parent/guardian: _____ Date: _____

Signature of parent/guardian: _____ Date: _____

PRIOR TO PARTICIPATION IN ANY CONDITIONING, TRYOUT, PRACTICE SESSION, OR PLAY IN ANY INTERSCHOLASTIC ATHLETIC ACTIVITY, THE STUDENT-ATHLETE MUST SUBMIT THIS FORM FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS TO THE COACH OF THE ACTIVITY. FAILURE TO SUBMIT THIS FORM WILL DELAY THE ELIGIBILITY OF THE STUDENT-ATHLETE TO JOIN THE TEAM

Preparticipation Physical Evaluation 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.)

Date of Exam: _____

Name: _____ Date of Birth _____

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

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

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: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> 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 ever 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: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> 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 crutches?		
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 (males), 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		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Signature of Athlete: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

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Preparticipation Physical Evaluation

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam: _____

Name: _____ Date of Birth: _____

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

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

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: _____

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, 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?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
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, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) 			
Eyes/ears/nose/throat <ul style="list-style-type: none"> Pupils equal Hearing 			
Lymph nodes			
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) 			
Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses 			
Lungs			
Abdomen			
Genitourinary (males only) ^b			
Skin <ul style="list-style-type: none"> HSV, lesions suggestive of MRSA, tinea corporis 			
Neurologic ^c			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional <ul style="list-style-type: none"> Duck-walk, single leg hop 			

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider 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

- Pending further evaluation
- For any sports
- For certain sports _____

Reason: _____

Recommendations: _____

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam 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

Preparticipation Physical Evaluation CLEARANCE FORM

Name _____ Sex M F Age _____ Date of birth _____

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

- Not cleared
- Pending further evaluation
- For any sports
- For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam 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

EMERGENCY INFORMATION

Allergies _____

Other information _____

