SCHOOL_____ STUDENT ID#_____

CHEROKEE COUNTY SCHOOL DISTRICT ATHLETIC INFORMATION AND CONSENT FORMS

(PLEASE PRINT)

Name_____ _____ _____ Male ____ Female ____
LAST FIRST MIDDLE

Address_____ _____ _____ _____
STREET CITY STATE ZIP

Telephone (home)_____ Date of Birth_____

Date entered 9th grade_____ Your grade level for the current school year_____

Father's Name _____ Father's Work Number _____ Cell_____

Mother's Name_____ Mother's Work Number_____ Cell_____

Student resides with (Names of Parent(s)/Guardian) _____
(If Guardian, submit copies of Court Order for Guardianship)

The student is domiciled at the above address located in the _____ high school district (school must be notified if student moves from the above address).

Have you attended this Cherokee County School for at least one full school year? Yes_____ No _____

EMERGENCY CONTACT INFORMATION
In an event the father or mother cannot be reached, these persons should be contacted regarding any situations which any officer, agent, or employee of the Cherokee County School District finds to be an emergency situation involving the student

Name	Relationship	Home Phone	Work Phone
Name	Relationship	Home Phone	Work Phone

PARENTAL CONSENT FOR PARTICIPATION

WARNING: Although participation in supervised inter-scholastic athletics and activities and intra-scholastic athletic clubs and activities may be one of the least hazardous in which students will engage, **BY ITS NATURE, PARTICIPATION IN INTER-SCHOLASTIC ATHLETICS AND INTRA-SCHOLASTIC SPORTS CLUBS INCLUDE A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG TERM CATASTROPHIC, INCLUDING PERMANENT PARALYSIS FROM THE NECK DOWN OR DEATH.** Although serious injuries are not common in supervised athletic programs or athletic clubs, it is possible only to minimize, not eliminate this risk.

Participants can and have the responsibility to help reduce the chance of injury. **PARTICIPANTS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACHES OR CLUB SUPERVISORS, FOLLOW A PROPER CONDITIONING PROGRAM AND INSPECT THEIR EQUIPMENT DAILY.**

By signing this permission form, you acknowledge that you have read and understand the warning. PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PERMISSION FORM AND MAY NOT PARTICIPATE IN THE ACTIVITY.

We hereby consent for _____ to:

1. Compete in athletics at _____ School of the Cherokee County School District in Georgia High School Association approved sports except those CROSSED out below:

Baseball	Basketball	Cheerleading	Cross Country	Football	Golf	Gymnastics	Lacrosse
Soccer	Softball	Swimming	Tennis	Track	Weight Training	Wrestling	Volleyball

2. To accompany any school team or sports club of which the student is a member on any of its local or out of town trips.
3. I hereby verify that the information contained within this form is correct and understand that any false information may result in my son/daughter being declared ineligible for participation in sports.
4. Students found illegally enrolled out of their school attendance zone could be ruled ineligible for GHSA competition for one (1) full year.
5. By execution hereof I hereby release and forever discharge the Cherokee County School District its agents and employees from any and all liability resulting from the intentional or negligent acts or conduct of the District its agents and/or employees.

This acknowledgement of risk and consent to allow participation shall remain in effect until revoked in writing.

_____ _____
Signature(s) of Parent(s) or Guardians(s) Date

_____ _____
Signature of Student – Athlete Date

Revised 4/11/17

INSURANCE INFORMATION

Please INITIAL one of the following statements regarding insurance coverage for your son/daughter for the _____-_____ school year, then sign below.

_____My son/daughter is adequately and currently covered by accident insurance that will cover injuries sustained while participating in any school authorized activity (including, but not limited to Varsity or Junior Varsity Football).

Company Providing Insurance _____ Name of Insured _____ Policy Number _____

_____I have purchased the Benefit Plan provided by the Cherokee County School District, I understand this is a supplemental policy. My signed copy of this Benefit Plan is on file at _____school

Signature(s) of Parent(s) or Guardian(s) _____ Date _____

AUTHORIZATION

I certify that the medical history on this form is complete and accurate. I understand that this will serve as the basis for determining that my child may compete in middle/high school athletics within the Cherokee County Schools. I also understand this medical evaluation is only to determine fitness for athletics and is not to take place of regular medical examinations. In case of an emergency or accident on school grounds or during any school activity involving my child, which in the opinion of school authorities present requires immediate medical or surgical attention, I hereby grant permission to said school authorities to obtain the services of a physician or to transport my child to the hospital if it is deemed necessary by school authorities. I hereby grant permission, also, to said physician to treat said condition unless I am present and request otherwise or until I request otherwise.

I also hereby grant permission for qualified athletic trainers retained by the Cherokee County School District to render any preventative medical treatment, first aid, emergency medical care, or rehabilitative medical treatment deemed reasonably necessary to protect the health and well-being of the above named student.

I understand that the terms hereof apply to any injury, illness or other medical problem or emergency that arises as a result of or in connection with any aspect of athletic participation for Cherokee County Schools, including tryouts, practice, conditioning, meetings, games, and travel. I also understand that reasonable efforts will be made to contact parents or legal guardians before any serious or involved medical treatment.

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 athletic programs of the Cherokee County School District. I further understand that a basic medical screening (the required physical exam) is general in nature and limited in its scope and does not indicate or assure me that my child is completely free from impairments. If I wish for a more detailed physical exam to be performed upon my child/ward then it is my responsibility to arrange and pay for such an exam. If this more detailed exam is performed, it is my responsibility to notify the Cherokee County School District, and its appropriate employees, of any potential medical problems uncovered by any physical exam given to my child/ward 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 child/ward, for myself, my estate, my heirs, my administrators, my executors, my assignees, my agents, my successors, and for all members of my family, and to indemnify, release, defend, exonerate, discharge and hold harmless the Cherokee 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 Cherokee County School District or indemnified party arising out of any injuries to my child/ward 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 athletic programs provided by the Cherokee County School District.
My signature below attests that I have read, understand 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.

_____

***Signature(s) of Parent(s) or Guardian(s) Date Relation to Student**

_____

***Signature of Student Athlete Date**

THIS ACKNOWLEDGEMENT OF AUTHORIZATION SHALL REMAIN IN EFFECT UNTIL REVOKED IN WRITING.

Signature(s) of Parent(s) or Guardian(s) _____ Relation to Student _____ Date _____

STUDENT TRANSPORTATION RELEASE AND CONSENT FORM

While the Cherokee County School District provides transportation through the utilization of the District bus fleet for many extracurricular events, in some cases school sponsored transportation is not available. In those instances, it is necessary for the parent/guardian to make arrangements for transportation. The Cherokee County School District strongly discourages students from riding with other students to and from extracurricular events.

I, _____, parent or guardian of _____(student) hereby give my permission for my student to provide his/her own transportation to/from extracurricular events, and I, parent/guardian of the student listed above, hereby give my permission for my student to ride with another parent, including coach/sponsor to/from extracurricular events.

CONSENT AND RELEASE

I hereby consent on behalf of the student named above to participate in school-sponsored trips. I understand that transportation may or may not be provided by the Cherokee County School District. In the event transportation is not provided by the Cherokee County School District, transportation will be the student's and parent's/guardian's responsibility. If any emergency medical procedure or treatments are required by the student during the trip, I consent to the trip's supervisor taking, arranging for or consenting to the procedures or treatment in his or her discretion. I further release and waive and further agree to indemnify and hold harmless and reimburse the Cherokee County School District, the Board of Education, its successors and assigns, its members, agents, employees, and representatives thereof, as well as the trip supervisor from and against any claim which I, any other person, firm, corporation, or entity may have or claim to have, known or unknown, directly or indirectly, from any losses, damages or injuries arising out of, during, or in connection with the student's participation in the activity, any trip associated with the activity, or the rendering or emergency medical procedures or treatment, if any.

_____ _____

Signature(s) of Parent(s) or Guardian(s) Date

RELEASE OF INFORMATION

I hereby authorize the release of any and all information relating to the athletic participation of the above named student to the media and to all college recruiters, including any medical information concerning injury or illness, any biographical information, and any other information related to the athletic participation, including ability, attitude and conduct.

_____ _____ _____

Signature of Student Signature of Parent/Guardian Date

GUIDELINES FOR OUTDOOR EXTRACURRICULAR ACTIVITIES DURING EXTREME HOT AND HUMID WEATHER

I hereby verify that I have received and reviewed the Cherokee County School District Guidelines for Outdoor Extracurricular Activities During Extreme Hot and Humid Weather.

_____ _____ _____

Signature of Student Signature of Parent/Guardian Date

STUDENT ATHLETE CONCUSSION DIAGNOSIS AND MANAGEMENT PROGRAM

I have read the information concerning usage of the Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT™) and understand its contents. I have been given an opportunity to ask questions and all have been answered to my satisfaction. I understand that participation in the ImPACT™ concussion baseline testing is highly recommended but not required for athletes in Cherokee County schools. I also understand that the ImPACT™ testing is merely a tool to assist Medical Professionals in the diagnosis and subsequent treatment of potentially serious injuries, the ImPACT™ testing IS NOT a substitute for treatment by a medical professional. **I acknowledge that if my child is suspected of receiving a concussion causing injury, my child WILL NOT be allowed to participate in athletics until cleared by a medical doctor.**

Please INITIAL one of the choices below, sign and date:

_____ YES, I give permission for my child, _____, to participate in baseline testing with the ImPACT™ program.

_____ NO, I do not give permission for my child, _____, to participate in baseline testing.

_____ _____

Signature(s) of Parent(s) or Guardian(s) Date

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

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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 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: ☐ 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 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?		

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
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

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).

EXAMINATION		
Height _____ Weight _____ ☐ Male ☐ Female		
BP ____/____ (____/____) Pulse _____ Vision R 20/_____ L 20/_____ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • 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 • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]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

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

  Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation 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 preparticipation 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 _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Georgia High School Association
Student/Parent Concussion Awareness Form

SCHOOL: _____

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 GHSA 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.)

BY-LAW 2.68: GHSA CONCUSSION POLICY: In accordance with Georgia law and national playing rules published by the National Federation of State High School Associations, any athlete who exhibits signs, symptoms, or behaviors consistent with a concussion shall be immediately removed from the practice or contest and shall not return to play until an appropriate health care professional has determined that no concussion has occurred. (NOTE: An appropriate health care professional may include licensed physician (MD/DO) or another licensed individual under the supervision of a licensed physician, such as a nurse practitioner, physician assistant, or certified athletic trainer who has received training in concussion evaluation and management.

a) No athlete is allowed to return to a game or a practice on the same day that a concussion (a) has been diagnosed, OR (b) cannot be ruled out.

b) Any athlete diagnosed with a concussion shall be cleared medically by an appropriate health care professional prior to resuming participation in any future practice or contest. The formulation of a gradual return to play protocol shall be a part of the medical clearance.

By signing this concussion form, I give _____ High School permission to transfer this concussion form to the other sports that my child may play. I am aware of the dangers of concussion and this signed concussion form will represent myself and my child during the 2017-2018 school year. This form will be stored with the athletic physical form and other accompanying forms required by the _____ School System.

I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.

_____	_____	_____
Student Name (Printed)	***Student Name (Signed)***	***Date***
_____	_____	_____
Parent Name (Printed)	***Parent Name (Signed)***	***Date***

(Revised: 3/17)

CHEROKEE COUNTY AND CHEROKEE HIGH SCHOOL
CODE OF CONDUCT

The Cherokee County School District and Cherokee High School will:

1. A commitment to establishing and promoting a positive image of the program, the school and the school system.
2. Adherence to the Cherokee County School District's Discipline Code.
3. Expect that students will not be involved in criminal acts or acts of moral turpitude.
4. Establish team/activity rules.

Violations of the Student Activity Code of Conduct that are verified through a reliable source (school administrator, teacher, coach/sponsor, staff member, parent of involved student(s), law enforcement agency, etc.) will be investigated thoroughly by Cherokee High School. The violation(s) may result in disciplinary action and/or suspension from extra-curricular/interscholastic activities, regardless of whether the offense occurred at a school-related or non-related activity. Based on the decision of the principal of Cherokee High School (or designee), a participant in extracurricular/interscholastic activities may encounter one or more of the following dispositions for Code of Conduct infractions:

1. Extra practice time, lap time, or other forms of conditioning.
2. Sponsor/student conference.
3. Sponsor/parent conference.
4. Loss of position.
5. Loss of awards privilege.
6. Loss of performance or participation privilege which can include a suspension of part or all of current season, and/or part or all of the next season in which he/she is a participant.
7. Permanent suspension for all extracurricular/interscholastic programs for the remainder of their school year.
8. Cherokee High School reserved the right to permanently dismiss a student from all extracurricular/interscholastic programs for the remainder of their school career upon the arrest or conviction of felony crimes or crimes of moral turpitude.
9. A parent/guardian will be notified of the student's suspension.
10. A suspension report will be filed with the Office of Student Activities and Athletics.

In addition to the above minimum guidelines, students will abide by all standards and guidelines established in the Georgia High School Association Constitution and By-Laws and the Cherokee County Discipline Code and/or Local, State, or Federal Laws, will not regain eligibility by transferring to another Cherokee County School.

I have been given a copy of the team/activity rules by the coach. I have read these rules and agree to abide by them. I have read the above Cherokee County and Cherokee High School Code of Conduct and agree to abide by them while participating.

_____
Student Signature

_____
Parent Signature

_____
Student's Name (Printed)

_____
Activities

ATHLETIC EMERGENCY INFORMATION

03/21/2014

Student's Legal Last Name | Legal First Name | Middle Name | Name called

Residential Address

Mailing Address, if different

Student Home Phone

Student's primary contacts

Contact name | Relationship | Home Phone | Work / Alt Phone | Cell Phone

Primary Email | Employer

Contact name | Relationship | Home Phone | Work / Alt Phone | Cell Phone

Primary Email | Employer

****

ANY ALLERGIES OR MEDICAL CONDITION: YES ____ NO ____ If Yes, Explain:

****

Physician Name | Physician Telephone

Insurance Carrier | Policy Number

EMERGENCY CONTACT INFORMAITON (Other Than Parent)

Contact name	Relationship	Home Phone	Work / Alt Phone	Cell Phone

I DO ____ DO NOT _____ grant consent and desire emergency treatment to my child

_____ with the nearest available doctor or hospital. I understand that the doctor or hospital bill is my responsibility.

Parent/Legal Guardian Signature | Date