

## **2026 East Coweta Softball**

### **Information and Dates**

- Dragonfly App - Must have physical, Emergency Medical Treatment/Extracurricular Authorization form (must be notarized), and all other virtual forms signed in Dragonfly under *East Coweta High School* before trying out.
- Must pass 3 out of 4 classes and be on track to graduate. All incoming Freshmen are academically eligible.

### **Important Dates for rising 9th-12th graders**

- Tryouts at ECHS Softball Field

**May 4-6**

4:00 pm - 5:45 pm

(rising 8th graders cannot tryout in May - see below)

### **Important Dates for rising 8th graders & new enrollees and those offered to trying out again**

- Evaluations and Workouts at ECHS Softball Field  
Monday, July 20 @ 9:00am  
Tuesday, July 21 @ 9:00am

**-All Softball Workouts starts on July 22 at 9:00am**

***Any questions, please email:***

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# GET STARTED WITH DRAGONFLY



DragonFly makes sports and activities more organized with easy-to-use digital forms, health records and team communication tools.



## PARENTS & STUDENTS

- 1 Download the DragonFly MAX app from the App Store or Google Play.
- 2 Tap 'Get Started' and 'Sign Up for Free' then follow the prompts to create your Parent account with your own email address.  
*Note: please do not create an account with your child's name or contact information – you will get the chance to add your child soon!*
- 3 Verify your account with the verification ID sent to your email address.
- 4 Tap 'Connect to your school' to select 'Parent' as your role and search for your child's school.
- 5 After selecting your child's school, tap 'Join' to request access. An administrator at your school will approve your request.
- 6 Tap 'Set up your children' and follow the prompts to add your kid(s) and fill out their participation forms.



## ATHLETIC DIRECTORS, COACHES & SCHOOL ADMINISTRATORS

- 1 Visit [dragonflymax.com](http://dragonflymax.com) and click the 'Log In/Sign Up' button.
- 2 Click 'Sign Up for Free' to create your account with your school email address.
- 3 Verify your account with the verification ID sent to your email address.
- 4 Click the 'Get Started' button to select your role and search for your school.
- 5 After selecting your school, tap 'Join' to request access. You will see a list of administrators at your school who can approve your request. If you're the first person to request access to your school, a member of the DragonFly team will verify your role and approve your request.

### PREFER TO DO THIS ON YOUR COMPUTER?

Visit [dragonflymax.com](http://dragonflymax.com) and click 'Log In/Sign Up' to get started.

# ■ PREPARTICIPATION PHYSICAL EVALUATION

## HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Sex assigned at birth: \_\_\_\_\_

List past and current medical conditions. \_\_\_\_\_

Have you ever had surgery? If yes, list all past surgical procedures. \_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). \_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). \_\_\_\_\_

Patient Health Questionnaire Version 4 (PHQ-4)  
 Over the last 2 weeks, how often have you been bothered by any of the following problems? (check box next to appropriate number)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

(A sum of  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

(First Name)	GENERAL QUESTIONS		Yes	No	
	(Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)				
	1. Do you have any concerns that you would like to discuss with your provider?	<input type="checkbox"/>	<input type="checkbox"/>		
	2. Has a provider ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>		
3. Do you have any ongoing medical issues or recent illness?	<input type="checkbox"/>	<input type="checkbox"/>			
(Last Name)	HEART HEALTH QUESTIONS ABOUT YOU		Yes	No	
	4. Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>		
	5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>		
	6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>		
	7. Has a doctor ever told you that you have any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	<input type="checkbox"/>	<input type="checkbox"/>			

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)		Yes	No	
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>		
10. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Yes	No	
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?	<input type="checkbox"/>	<input type="checkbox"/>		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	<input type="checkbox"/>	<input type="checkbox"/>		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	<input type="checkbox"/>	<input type="checkbox"/>		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>
MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you ever become ill while exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you or does someone in your family have sickle cell trait or disease?	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you ever had or do you have any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL QUESTIONS (CONTINUED)	Yes	No
25. Do you worry about your weight?	<input type="checkbox"/>	<input type="checkbox"/>
26. Are you trying to or has anyone recommended that you gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
27. Are you on a special diet or do you avoid certain types of foods or food groups?	<input type="checkbox"/>	<input type="checkbox"/>
28. Have you ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>

**Explain "Yes" answers here.**

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**I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.**

Signature of athlete: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

Date: \_\_\_\_\_

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2023 This form has been modified for use by the GHSA

# ■ PREPARTICIPATION PHYSICAL EVALUATION

## PHYSICAL EXAMINATION FORM

Name: \_\_\_\_\_ (First Name) \_\_\_\_\_ (Last 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, e-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-enhancing 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 (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
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"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul>	<input type="checkbox"/>	
Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	
Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Skin <ul style="list-style-type: none"> <li>Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis</li> </ul>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck	<input type="checkbox"/>	
Back	<input type="checkbox"/>	
Shoulder and arm	<input type="checkbox"/>	
Elbow and forearm	<input type="checkbox"/>	
Wrist, hand, and fingers	<input type="checkbox"/>	
Hip and thigh	<input type="checkbox"/>	
Knee	<input type="checkbox"/>	
Leg and ankle	<input type="checkbox"/>	
Foot and toes	<input type="checkbox"/>	
Functional <ul style="list-style-type: none"> <li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>	<input type="checkbox"/>	

<sup>a</sup> Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### MEDICAL ELIGIBILITY FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Medically eligible for all sports without restriction

Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

\_\_\_\_\_  
 Medically eligible for certain sports

\_\_\_\_\_  
 Not medically eligible pending further evaluation

Not medically eligible for any sports

Recommendations: \_\_\_\_\_

\_\_\_\_\_  
I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

### SHARED EMERGENCY INFORMATION

Allergies: \_\_\_\_\_

\_\_\_\_\_  
Medications: \_\_\_\_\_

\_\_\_\_\_  
Other information: \_\_\_\_\_

\_\_\_\_\_  
Emergency contacts: \_\_\_\_\_

\_\_\_\_\_  
 LAST (Student's Name) FIRST MIDDLE SCHOOL YEAR

EMERGENCY MEDICAL TREATMENT INFORMATION

STUDENT'S NAME:	DATE OF BIRTH:	AGE:
PARENT/GUARDIAN NAME:	HOME PHONE NO:	PARENT/GUARDIAN WORK NO:
FAMILY PHYSICIAN:	PHYSICIAN NUMBER:	
SPECIAL MEDICAL CONDITIONS OF STUDENT:	STUDENTS IS ALLERGIC TO:	

PERMISSION FOR MEDICAL TREATMENT

I/WE grant to the school personnel my/our permission to act on my/our behalf in securing medical attention for \_\_\_\_\_ in case of any medical emergency while participating in said activity. The local emergency facilities have my/our permission to treat \_\_\_\_\_ for any illness/injury that occurs while participating in said activity wherever conducted. I/We also understand that I/We are totally responsible for any costs incurred for medical attention.

I/We further verify that \_\_\_\_\_ is covered under the following insurance policy:

Name of Insurance Company:	
Policy Number:	
Named Insured:	
Persons Covered:	
Policy Expiration Date:	

PARENT(S)/GUARDIAN(S) SIGNATURE: \_\_\_\_\_

**\*\* Please continue on the back of this form. \*\***

**EXTRACURRICULAR AUTHORIZATION FORM**

I/We desiring that \_\_\_\_\_ participate fully in various interscholastic and extracurricular activities available through the Coweta County School System, hereby authorize and grant my/our permission for \_\_\_\_\_ to participate in the following extracurricular activities. I/We realize that such activities involve the potential for injury which is inherent in all extracurricular or sporting events. I/We hereby acknowledge that even with the best teaching and coaching, the use of the most advanced equipment, and the requirement of strict observance of all rules, injuries are still possible. I/We further realize that injuries received can be so severe as to result in total disability, paralysis, or even death. I/We hereby acknowledge that I/We have read and understand this warning and We hereby give my/our permission for \_\_\_\_\_ to participate in \_\_\_\_\_ and verify that he/she has adequate coverage of current accident and/or health insurance policy. This shall constitute the affidavit referenced in Board Policy JGA

PARENT(S)/GUARDIAN(S) SIGNATURE: \_\_\_\_\_  
**(MUST BE SIGNED IN FRONT OF A NOTARY)**

Sworn to and subscribed before me  
this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public  
My Commission Expires: \_\_\_\_\_

I/We hereby acknowledge that I/We have read, understand and completed this document with full and complete understanding of its terms and that the information contained herein is true and correct. I/We give permission for my/our student to accompany any school team of which the student is a member on any of its local or out of town trips.

This \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

PARENT(S)/GUARDIAN(S) SIGNATURE: \_\_\_\_\_

STUDENT'S NAME \_\_\_\_\_ GRADE \_\_\_\_\_