

Must take to  
physical

Athlete's Name: \_\_\_\_\_ DOB \_\_\_\_\_

**Consent for Treatment.** I, the athlete, or my representative, wishes to participate in the Reid Sport Medicine High School Athletic Physicals program. I understand that some of the individuals that are providing all or a portion of the examination may not be employees or agents of Reid Hospital and Health Care Services (Reid Hospital), Reid Rehabilitation Services (Reid Rehab) or Reid Physician Associates (RPA). I authorize the participating allied health personnel and physician, regardless of their employment status with Reid Hospital, Reid Rehab or RPA to render a pre-participation athletic physical examination on me. I understand that Reid Hospital, Reid Rehab and RPA are not responsible for those individuals who are not their employee. I understand that the practice of medicine is not an exact science and acknowledge that no guarantee has been made to me as to the result of this examination. I understand that it is my right to consent or to refuse consent for this examination. I understand that the information and forms for this examination will be forwarded to the athlete's school system and maintained in part by Reid Hospital. I understand that Reid Hospital, Reid Rehab and RPA will not be responsible for any valuables brought to any Reid Hospital, Reid Rehab or RPA facility by me.

I have read or had the opportunity to read the Consent for Treatment or it has been fully explained to me, and I am satisfied that I understand its content and significance. My consent is given freely, voluntarily and without reservation.

\_\_\_\_\_  
Patient or Responsible Person's signature

\_\_\_\_\_  
Date/Time

(if 18 years or older and appropriate)

Reid Hospital & Health Care Services  
Richmond, IN 47374 (765) 983-3000  
**General Consent for Pre-participation  
Athletic Physical Examination**

# PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM



(Note: This form is to be filled out by the patient and parent prior to examination. The examiner should keep a copy of 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	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
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: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
<b>HEART HEALTH QUESTIONS ABOUT YOU</b>	<b>Yes</b>	<b>No</b>	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
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: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
<b>HEART HEALTH QUESTIONS ABOUT YOUR FAMILY</b>	<b>Yes</b>	<b>No</b>	39. Have you ever been unable to move your arms or legs after being hit or falling?		
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)?			40. Have you ever become ill while exercising in the heat?		
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?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
<b>BONE AND JOINT QUESTIONS</b>	<b>Yes</b>	<b>No</b>	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
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)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			<b>FEMALES ONLY</b>		
25. Do you have any history of juvenile arthritis or connective tissue disease?			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 \_\_\_\_\_

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# PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM



*(The physical examination must be performed on or after April 1 by a physician holding an unlimited license to practice medicine, a nurse practitioner or a physician assistant to be valid for the following school year.) – IHSAA By-Law 3-10*

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 things?
  - 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 _____	Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
<b>MEDICAL</b>	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, brachnodactyly, arm span > height, hyperaxia, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat Papils equal Hearing		
Lymph nodes		
Heart Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI)		
Pulses Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
<b>MUSCULOSKELETAL</b>		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional Duck-walk, single leg hop		

Consider ECG, echocardiogram, and referral to cardiologist for abnormal cardiac history of exam.  
Consider (6) exam if in private setting. Having third party present is recommended.  
Consider cognitive evaluation or baseline neurocognitive 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). *(The physical examination must be performed on or after April 1 by a physician holding an unlimited license to practice medicine, a nurse practitioner or a physician assistant to be valid for the following school year.) – IHSAA By-Law 3-10*

Name of physician (print/type) (MD, DO, NP, or PA) \_\_\_\_\_ Date \_\_\_\_\_

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

Signature of physician (MD, DO, NP, or PA) \_\_\_\_\_ License # \_\_\_\_\_

# ■ PREPARTICIPATION PHYSICAL EVALUATION IHSAA ELIGIBILITY RULES



## INDIVIDUAL ELIGIBILITY RULES (Grades 9 through 12)

**ATTENTION ATHLETE:** Your school is a member of the IHSAA and follows established rules. To be eligible to represent your school in interschool athletics, you:

1. must be a regular bona fide student in good standing in the school you represent; must have enrolled not later than the fifteenth day of the current semester.
2. must have completed 10 separate days of organized practice in said sport under the direct supervision of the high school coaching staff preceding date of participation in interschool contests. (Excluding Girls Golf – See Rule 101)
3. must have received passing grades at the end of their last grading period in school in at least seventy percent (70%) of the maximum number of full credit subjects (or the equivalent) that a student can take and must be currently enrolled in at least seventy percent (70%) of the maximum number of full credit subjects (or the equivalent) that a student can take. Semester grades take precedence.
4. must not have reached your twentieth birthday prior to or on the scheduled date of the IHSAA State Finals in a sport.
5. must have been enrolled in your present high school last semester or at a junior high school from which your high school receives its students . . .
  - . . . unless you are entering the ninth grade for the first time.
  - . . . unless you are transferring from a school district or territory with a corresponding bona fide move on the part of your parents.
  - . . . unless you are a ward of a court; you are an orphan, you reside with a parent, your former school closed, your former school is not accredited by the state accrediting agency in the state where the school is located, your transfer was pursuant to school board mandate, you attended in error a wrong school, you transferred from a correctional school, you are emancipated, you are a foreign exchange student under an approved CSIET program. You must have been eligible from the school from which you transferred.
6. must not have been enrolled in more than eight consecutive semesters beginning with grade 9.
7. must be an amateur (have not participated under an assumed name, have not accepted money or merchandise directly or indirectly for athletic participation, have not accepted awards, gifts, or honors from colleges or their alumni, have not signed a professional contract).
8. must have had a physical examination between April 1 and your first practice and filed with your principal your completed Consent and Release Certificate.
9. must not have transferred from one school to another for athletic reasons as a result of undue influence or persuasion by any person or group.
10. must not have received in recognition of your athletic ability, any award not approved by your principal or the IHSAA.
11. must not accept awards in the form of merchandise, meals, cash, etc.
12. must not participate in an athletic contest during the IHSAA authorized contest season for that sport as an individual or on any team other than your school team. (See Rule 15-1a) (Exception for outstanding student-athlete – See Rule 15-1b)
13. must not reflect discredit upon your school nor create a disruptive influence on the discipline, good order, moral or educational environment in your school.
14. students with remaining eligibility must not participate in tryouts or demonstrations of athletic ability in that sport as a prospective post-secondary school student-athlete. Graduates should refer to college rules and regulations before participating.
15. must not participate with a student enrolled below grade 9.
16. must not, while on a grade 9 junior high team, participate with or against a student enrolled in grade 11 or 12.
17. must, if absent five or more days due to illness or injury, present to your principal a written verification from a physician licensed to practice medicine, stating you may participate again. (See Rule 3-11 and 9-14.)
18. must not participate in camps, clinics or schools during the IHSAA authorized contest season. Consult your high school principal for regulations regarding out-of-season and summer.
19. girls shall not be permitted to participate in an IHSAA tournament program for boys where there is an IHSAA tournament program for girls in that sport in which they can qualify as a girls tournament entrant.

***This is only a brief summary of the eligibility rules.***

***You may access the IHSAA Eligibility Rules (By-Laws) at [www.ihsaa.org](http://www.ihsaa.org)***

***Please contact your school officials for further information and before participating outside your school.***

*(Consent & Release Certificate - on back or next page)*

■ PREPARTICIPATION PHYSICAL EVALUATION  
**CONSENT & RELEASE CERTIFICATE**



**I. STUDENT ACKNOWLEDGMENT AND RELEASE CERTIFICATE**

- A. I have read the IHSAA Eligibility Rules (*next page or on back*) and know of no reason why I am not eligible to represent my school in athletic competition.
- B. If accepted as a representative, I agree to follow the rules and abide by the decisions of my school and the IHSAA.
- C. I know that athletic participation is a privilege. I know of the risks involved in athletic participation, understand that serious injury, and even death, is possible in such participation, and choose to accept such risks. I voluntarily accept any and all responsibility for my own safety and welfare while participating in athletics, with full understanding of the risks involved, and agree to release and hold harmless my school, the schools involved and the IHSAA of and from any and all responsibility and liability, including any from their own negligence, for any injury or claim resulting from such athletic participation and agree to take no legal action against my school, the schools involved or the IHSAA because of any accident or mishap involving my athletic participation.
- D. I consent to the exclusive jurisdiction and venue of courts in Marion County, Indiana for all claims and disputes between and among the IHSAA and me, including but not limited to any claims or disputes involving injury, eligibility or rule violation.
- E. I give the IHSAA and its assigns, licensees and legal representatives the irrevocable right to use my picture or image and any sound recording of me, in all forms and media and in all manners, for any lawful purposes.

**I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE PROVISION. (to be signed by student)**

Date: \_\_\_\_\_ Student Signature: (X) \_\_\_\_\_

Printed: \_\_\_\_\_

**II. PARENT/GUARDIAN/EMANCIPATED STUDENT CONSENT, ACKNOWLEDGMENT AND RELEASE CERTIFICATE**

- A. Undersigned, a parent of a student, a guardian of a student or an emancipated student, hereby gives consent for the student to participate in the following interschool sports **not marked out**:  
**Boys Sports:** Baseball, Basketball, Cross Country, Football, Golf, Soccer, Swimming, Tennis, Track, Wrestling.  
**Girls Sports:** Basketball, Cross Country, Golf, Gymnastics, Soccer, Softball, Swimming, Tennis, Track, Volleyball.
- B. Undersigned understands that participation may necessitate an early dismissal from classes.
- C. Undersigned consents to the disclosure, by the student's school, to the IHSAA of all requested, detailed financial (athletic or otherwise), scholastic and attendance records of such school concerning the student.
- D. Undersigned knows of and acknowledges that the student knows of the risks involved in athletic participation, understands that serious injury, and even death, is possible in such participation and chooses to accept any and all responsibility for the student's safety and welfare while participating in athletics. With full understanding of the risks involved, undersigned releases and holds harmless the student's school, the schools involved and the IHSAA of and from any and all responsibility and liability, including any from their own negligence, for any injury or claim resulting from such athletic participation and agrees to take no legal action against the IHSAA or the schools involved because of any accident or mishap involving the student's athletic participation.
- E. Undersigned consents to the exclusive jurisdiction and venue of courts in Marion County, Indiana for all claims and disputes between and among the IHSAA and me or the student, including but not limited to any claims or disputes involving injury, eligibility, or rule violation.
- F. Undersigned gives the IHSAA and its assigns, licensees and legal representatives the irrevocable right to use any picture or image or sound recording of the student in all forms and media and in all manners, for any lawful purposes.
- G. Please check the **appropriate space**:
 

<input type="checkbox"/> The student has school student accident insurance.	<input type="checkbox"/> The student has football insurance through school.
<input type="checkbox"/> The student has adequate family insurance coverage.	<input type="checkbox"/> The student does not have insurance.

Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

**I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE PROVISION.**

(to be completed and signed by all parents/guardians, emancipated students; where divorce or separation, parent with legal custody must sign)

Date: \_\_\_\_\_ Parent/Guardian/Emancipated Student Signature: (X) \_\_\_\_\_

Printed: \_\_\_\_\_

Date: \_\_\_\_\_ Parent/Guardian Signature: (X) \_\_\_\_\_

Printed: \_\_\_\_\_

**CONSENT & RELEASE CERTIFICATE**

Indiana High School Athletic Association, Inc.  
 9150 North Meridian St., P.O. Box 40650  
 Indianapolis, IN 46240-0650

File In Office of the Principal  
 Separate Form Required for Each School Year



# Reid Sports Medicine

## REID HOSPITAL & HEALTH CARE SERVICES (Reid Hospital) CONSENT FOR TREATMENT, HEALTH CARE OPERATIONS AND AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FOR THE SCHOOL YEAR 2015-16.

I \_\_\_\_\_ (print or type name) consent to the provision of care.  
(Athlete's Name)

- I understand that this care may include medical treatment, special tests, exams, evaluation, treatment and rehabilitation of an injury, illness or disability that may impact my ability to participate in athletics. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.
- I understand and agree that others may assist or participate in providing care. This may include, but may not be limited to team physicians, athletic trainers, family physicians, school nurses and emergency medical personnel. As such, I understand that there will be open communication/access to the medical record, verbally, electronically, or in print, including but not limited to diagnosis, severity, playing status, plan of care, restrictions and limitations among the medical providers involved in my care. Under the direction of a certified athletic trainer, student athletic trainers may also provide care.
- I authorize Reid Hospital to provide information related to my care to my family/school/team physician, school nurse, coaches, athletic department personnel, school principals, EMS personnel, and such persons as needed for them to provide consultation, treatment, establish a plan of care and determine eligibility.
- I understand that release of my health record(s) will only be for the purpose stated on this form.
- I understand that the health record(s) released by Reid Hospital may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) Reid Hospital and its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- I understand that the Athletic Trainer may contact me via cell phone or text, but will not communicate confidential medical information via text.
- I understand that this Authorization is in effect from the date of the signature extending until July 31<sup>st</sup> of the year listed as school year above.
- I understand that I have the right to revoke this Authorization form at any time by sending a written request to Reid Hospital's Sports Health Manager. I understand that the revocation does not apply to any release of my health record(s) that may have taken place prior to the date the request to revoke the Authorization is received.
- I understand that the Notice of Privacy Practices document is posted in the Athletic Training Room at my school. I also understand that a copy of this Notice is available to me upon my request or by visiting the hospital's website at [www.reidhospital.org](http://www.reidhospital.org)

I agree to the release of information to the phone numbers, accounts and individuals listed as contacts in the Reid Sports Medicine Athlete Demographic form, but not limited to, injury occurrence, medical status, playing status and treatment plan by the following means:

Athlete's Signature

Date / Time

\*\*Parent or Guardian Signature

Date / Time

\*\*Parent or Guardian signature not necessary for College Students over the age of eighteen (18). Parent or Guardian signature is necessary for all high school students and all minors under eighteen (18) years of age and not an emancipated minor or otherwise not competent to give consent.

# REID SPORTS MEDICINE ATHLETE DEMOGRAPHICS FORM

(Please Print Clearly)

Nickname \_\_\_\_\_ Gender M F DOB \_\_\_\_\_ Year in school 5 6 7 8 Fr So Jr Sr 5th Year \_\_\_\_\_

Primary Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (leave blank if no home phone) \_\_\_\_\_

Parent's Cell # ( ) \_\_\_\_\_ Student's Cell # ( ) \_\_\_\_\_

Secondary Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sport 1 \_\_\_\_\_ Sport 2 \_\_\_\_\_ Sport 3 \_\_\_\_\_ Sport 4 \_\_\_\_\_

By listing a person as a contact you authorize the release of medical information to that individual. List in the order you would prefer to be contacted. Check box to authorize us to leave medical information on voice mail at this phone number.

Contact name	Relation	Home Phone	Cell Phone	Work Phone	E-Mail
1		<input type="checkbox"/> ( )	<input type="checkbox"/> ( )	<input type="checkbox"/> ( )	
2		<input type="checkbox"/> ( )	<input type="checkbox"/> ( )	<input type="checkbox"/> ( )	
3		<input type="checkbox"/> ( )	<input type="checkbox"/> ( )	<input type="checkbox"/> ( )	
4		<input type="checkbox"/> ( )	<input type="checkbox"/> ( )	<input type="checkbox"/> ( )	

Other individuals that are authorized to receive medical information \_\_\_\_\_

Specific individuals that are not authorized to receive medical information (i.e. estranged family members) \_\_\_\_\_

Medical and Environmental Allergies \_\_\_\_\_

Important medical alerts \_\_\_\_\_

Regular medications \_\_\_\_\_

Primary Insurance provider \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Policy Holder \_\_\_\_\_

Secondary Insurance provider \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Policy Holder \_\_\_\_\_

Primary Physician \_\_\_\_\_ Primary Dentist \_\_\_\_\_ Preferred Hospital Emergency Dept. \_\_\_\_\_

Legal	Name	First	Middle	Last	Initial	Signature	Date

**CENTERVILLE-ABINGTON COMMUNITY SCHOOLS 2017-2018  
STUDENT ATHLETE EMERGENCY CARD**

SPORTS: \_\_\_\_\_

STUDENT'S LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ MI: \_\_\_\_\_

GENDER: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY, STATE ZIP: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

MEDICAL ALERTS/INFORMATION: \_\_\_\_\_

INSURANCE COMPANY NAME: \_\_\_\_\_ POLICY NUMBER: \_\_\_\_\_

I hereby give my permission to the school principal or his/her designee to administer first aid to my child if I am unavailable or otherwise unable to provide authorization directly. In case of a medical emergency, my child may be transported to the hospital. It is understood that all expenses incurred in such situations shall be my responsibility and not the CACS nor any of its Board of Education Members, administration, faculty and other school personnel. This authorization is valid for the current school year or until such time I withdraw the authorization.

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE



# HEADS+UP

## CONCUSSION IN HIGH SCHOOL SPORTS

A FACT SHEET FOR **PARENTS**

### What is a concussion?

A concussion is a type of traumatic brain injury. Concussions are caused by a bump or blow to the head. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

You can’t see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

### What are the signs and symptoms of a concussion?

If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs of a concussion:

SYMPTOMS REPORTED BY ATHLETE	SIGNS OBSERVED BY PARENTS/GUARDIANS
<ul style="list-style-type: none"> <li>• Headache or “pressure” in head</li> <li>• Nausea or vomiting</li> <li>• Balance problems or dizziness</li> <li>• Double or blurry vision</li> <li>• Sensitivity to light</li> <li>• Sensitivity to noise</li> <li>• Feeling sluggish, hazy, foggy, or groggy</li> <li>• Concentration or memory problems</li> <li>• Confusion</li> <li>• Just “not feeling right” or “feeling down”</li> </ul>	<ul style="list-style-type: none"> <li>• Appears dazed or stunned</li> <li>• Is confused about assignment or position</li> <li>• Forgets an instruction</li> <li>• Is unsure of game, score, or opponent</li> <li>• Moves clumsily</li> <li>• Answers questions slowly</li> <li>• Loses consciousness (even briefly)</li> <li>• Shows mood, behavior, or personality changes</li> </ul>

### How can you help your child prevent a concussion or other serious brain injury?

- Ensure that they follow their coach’s rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.
- Make sure they wear the right protective equipment for their activity. Protective equipment should fit properly and be well maintained.
- Wearing a helmet is a must to reduce the risk of a serious brain injury or skull fracture.
  - However, helmets are not designed to prevent concussions. There is no “concussion-proof” helmet. So, even with a helmet, it is important for kids and teens to avoid hits to the head.

### What should you do if you think your child has a concussion?

**SEEK MEDICAL ATTENTION RIGHT AWAY.** A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to regular activities, including sports.

**KEEP YOUR CHILD OUT OF PLAY.** Concussions take time to heal. Don’t let your child return to play the day of the injury and until a health care professional says it’s OK. Children who return to play too soon—while the brain is still healing—risk a greater chance of having a repeat concussion. Repeat or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.

**TELL YOUR CHILD’S COACH ABOUT ANY PREVIOUS CONCUSSION.** Coaches should know if your child had a previous concussion. Your child’s coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

**If you think your teen has a concussion:**  
Don’t assess it yourself. Take him/her out of play.  
Seek the advice of a health care professional.

**It’s better to miss one game than the whole season.**

For more information, visit [www.cdc.gov/Concussion](http://www.cdc.gov/Concussion).



# HEADS+UP

## CONCUSSION IN HIGH SCHOOL SPORTS

A FACT SHEET FOR **ATHLETES**

### Concussion facts:

- A concussion is a brain injury that affects how your brain works.
- A concussion is caused by a bump, blow, or jolt to the head or body.
- A concussion can happen even if you haven't been knocked out.
- If you think you have a concussion, you should not return to play on the day of the injury and not until a health care professional says you are OK to return to play.

### What are the symptoms of a concussion?

Concussion symptoms differ with each person and with each injury, and they may not be noticeable for hours or days. Common symptoms include:

- Headache
- Confusion
- Difficulty remembering or paying attention
- Balance problems or dizziness
- Feeling sluggish, hazy, foggy, or groggy
- Feeling irritable, more emotional, or "down"
- Nausea or vomiting
- Bothered by light or noise
- Double or blurry vision
- Slowed reaction time
- Sleep problems
- Loss of consciousness

During recovery, exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse.

### What should I do if I think I have a concussion?

**DON'T HIDE IT. REPORT IT.** Ignoring your symptoms and trying to "tough it out" often makes symptoms worse. Tell your coach, parent, and athletic trainer if you think you or one of your teammates may have a concussion. Don't let anyone pressure you into continuing to practice or play with a concussion.

**GET CHECKED OUT.** Only a health care professional can tell if you have a concussion and when it's OK to return to play. Sports have injury timeouts and player substitutions so that you can get checked out and the team can perform at its best. The sooner you get checked out, the sooner you may be able to safely return to play.

**TAKE CARE OF YOUR BRAIN.** A concussion can affect your ability to do schoolwork and other activities. Most athletes with a concussion get better and return to sports, but it is important to rest and give your brain time to heal. A repeat concussion that occurs while your brain is still healing can cause long-term problems that may change your life forever.

### How can I help prevent a concussion?

Every sport is different, but there are steps you can take to protect yourself.

- Follow your coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

### If you think you have a concussion:

Don't hide it. Report it. Take time to recover.

**It's better to miss one game than the whole season.**

For more information, visit [www.cdc.gov/Concussion](http://www.cdc.gov/Concussion).



# **SUDDEN CARDIAC ARREST**

## *A Fact Sheet for Parents*

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### **FACTS**

Sudden cardiac arrest is a rare, but tragic event that claims the lives of approximately 500 athletes each year in the United States. Sudden cardiac arrest can affect all levels of athletes, in all sports, and in all age levels. The majority of cardiac arrests are due to congenital (inherited) heart defects. However, sudden cardiac arrest can also occur after a person experiences an illness which has caused an inflammation to the heart or after a direct blow to the chest.

### **WARNING SIGNS**

There may not be any noticeable symptoms before a person experiences loss of consciousness and a full cardiac arrest (no pulse and no breathing).

Warning signs can include a complaint of:

- Chest Discomfort
- Unusual Shortness of Breath
- Racing or Irregular Heartbeat
- Fainting or Passing Out

### **EMERGENCY SIGNS – Call EMS (911)**

If a person experiences any of the following signs, call EMS (911) immediately:

- *If an athlete collapses suddenly during competition*
- *If a blow to the chest from a ball, puck or another player precedes an athlete's complaints of any of the warning signs of sudden cardiac arrest*
- *If an athlete does not look or feel right and you are just not sure*

### **How can I help my child prevent a sudden cardiac arrest?**

Daily physical activity, proper nutrition, and adequate sleep are all important aspects of life-long health. Additionally, parents can assist student athletes prevent a sudden cardiac arrest by:

- Ensuring your child knows about any family history of sudden cardiac arrest (onset of heart disease in a family member before the age of 50 or a sudden, unexplained death at an early age)
- Ensuring your child has a thorough pre-season screening exam prior to participation in an organized athletic activity
- Asking if your school and the site of competition has an automatic defibrillator (AED) that is close by and properly maintained
- Learning CPR yourself
- Ensuring your child is not using any non-prescribed stimulants or performance enhancing drugs
- Being aware that the inappropriate use of prescription medications or energy drinks can increase risk
- Encouraging your child to be honest and report symptoms of chest discomfort, unusual shortness of breath, racing or irregular heartbeat, or feeling faint

### **What should I do if I think my child has warning signs that may lead to sudden cardiac arrest?**

1. *Tell your child's coach about any previous events or family history*
2. *Keep your child out of play*
3. *Seek medical attention right away*

# **SUDDEN CARDIAC ARREST**

## *A Fact Sheet for Student Athletes*

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### **FACTS**

Sudden cardiac arrest can occur even in athletes who are in peak shape. Approximately 500 deaths are attributed to sudden cardiac arrest in athletes each year in the United States. Sudden cardiac arrest can affect all levels of athletes, in all sports, and in all age levels. The majority of cardiac arrests are due to congenital (inherited) heart defects. However, sudden cardiac arrest can also occur after a person experiences an illness which has caused an inflammation to the heart or after a direct blow to the chest. Once a cardiac arrest occurs, there is very little time to save the athlete, so identifying those at risk before the arrest occurs is a key factor in prevention.

### **WARNING SIGNS**

There may not be any noticeable symptoms before a person experiences loss of consciousness and a full cardiac arrest (no pulse and no breathing).

Warning signs can include a complaint of:

- Chest Discomfort
- Unusual Shortness of Breath
- Racing or Irregular Heartbeat
- Fainting or Passing Out

### **EMERGENCY SIGNS – Call EMS (911)**

If a person experiences any of the following signs, call EMS (911) immediately:

- *If an athlete collapses suddenly during competition*
- *If a blow to the chest from a ball, puck or another player precedes an athlete's complaints of any of the warning signs of sudden cardiac arrest*
- *If an athlete does not look or feel right and you are just not sure*

### **How can I help prevent a sudden cardiac arrest?**

Daily physical activity, proper nutrition, and adequate sleep are all important aspects of life-long health. Additionally, you can assist by:

- Knowing if you have a family history of sudden cardiac arrest (onset of heart disease in a family member before the age of 50 or a sudden, unexplained death at an early age)
- Telling your health care provider during your pre-season physical about any unusual symptoms of chest discomfort, shortness of breath, racing or irregular heartbeat, or feeling faint, especially if you feel these symptoms with physical activity
- Taking only prescription drugs that are prescribed to you by your health care provider
- Being aware that the inappropriate use of prescription medications or energy drinks can increase your risk
- Being honest and reporting symptoms of chest discomfort, unusual shortness of breath, racing or irregular heartbeat, or feeling faint

### **What should I do if I think I am developing warning signs that may lead to sudden cardiac arrest?**

1. *Tell an adult – your parent or guardian, your coach, your athletic trainer or your school nurse*
2. *Get checked out by your health care provider*
3. *Take care of your heart*
4. *Remember that the most dangerous thing you can do is to do nothing*

CONCUSSION and SUDDEN CARDIAC ARREST  
ACKNOWLEDGEMENT AND SIGNATURE FORM FOR PARENTS AND STUDENT ATHLETES

Student Athlete's Name (Please Print): \_\_\_\_\_

Sport Participating In (Current and Potential): \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

IC 20-34-7 and IC 20-34-8 require schools to distribute information sheets to inform and educate student athletes and their parents on the nature and risk of concussion, head injury and sudden cardiac arrest to student athletes, including the risks of continuing to play after concussion or head injury. These laws require that each year, before beginning practice for an interscholastic sport, a student athlete and the student athlete's parents must be given an information sheet, and both must sign and return a form acknowledging receipt of the information to the student athlete's coach.

IC 20-34-7 states that an interscholastic student athlete, in grades 5-12, who is suspected of sustaining a concussion or head injury in a practice or game, shall be removed from play at the time of injury and may not return to play until the student athlete has received a written clearance from a licensed health care provider trained in the evaluation and management of concussions and head injuries, and at least twenty-four hours have passed since the injury occurred.

IC 20-34-8 states that a student athlete who is suspected of experiencing symptoms of sudden cardiac arrest shall be removed from play and may not return to play until the coach has received verbal permission from a parent or legal guardian for the student athlete to return to play. Within twenty-four hours, this verbal permission must be replaced by a written statement from the parent or guardian.

Parent/Guardian - please read the attached fact sheets regarding concussion and sudden cardiac arrest and ensure that your student athlete has also received and read these fact sheets. After reading these fact sheets, please ensure that you and your student athlete sign this form, and have your student athlete return this form to his/her coach.

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As a student athlete, I have received and read both of the fact sheets regarding concussion and sudden cardiac arrest. I understand the nature and risk of concussion and head injury to student athletes, including the risks of continuing to play after concussion or head injury, and the symptoms of sudden cardiac arrest.

\_\_\_\_\_  
(Signature of Student Athlete)

\_\_\_\_\_  
(Date)

I, as the parent or legal guardian of the above named student, have received and read both of the fact sheets regarding concussion and sudden cardiac arrest. I understand the nature and risk of concussion and head injury to student athletes, including the risks of continuing to play after concussion or head injury, and the symptoms of sudden cardiac arrest.

\_\_\_\_\_  
(Signature of Parent or Guardian)

\_\_\_\_\_  
(Date)