



PRE-PARTICIPATION PHYSICAL EVALUATION FORM (PPE)

The IHSAA Pre-participation Physical Evaluation (PPE) is the first and most important step in providing for the well-being of Indiana's high school athletes. The form is designed to identify risk factors prior to athletic participation by way of a thorough medical history and physical examination. The IHSAA, under the guidance of the Indiana State Medical Association's Committee on Sports Medicine, requires that the PPE Form be signed by a physician (MD or DO), nurse practitioner or physician's assistant holding a license to practice in the State of Indiana. In order to assure that these rigorous standards are met, both organizations endorse the following requirements for completion of the PPE Form:

1. The most current version of the IHSAA PPE Form must be used and may not be altered or modified in any manner.
2. The PPE Form must be signed by a physician (MD or DO), nurse practitioner or physician's assistant only after the medical history is reviewed, the examination performed, and the PPE Form completed in its entirety. No pre-signed or pre-stamped forms will be accepted.
3. **SIGNATURES**
 - The signature must be hand-written. No signature stamps will be accepted.
 - The signature and license number must be affixed on page three (3).
 - The parent signatures must be affixed to the form on pages two (2) and five (5).
 - The student-athlete signature must be affixed to pages two (2) and five (5).

Your cooperation will help ensure the best medical screening for Indiana's high school athletes.

PREPARTICIPATION PHYSICAL 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: _____ Grade: _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

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). _____

Are your required vaccinations current? _____

Patient Health Questionnaire Version 4 (PHQ-4)

Overall, during the last 2 weeks, how often have you been bothered by any of the following problems? (Circle Response.)

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

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

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

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
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)?		
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 poly-morphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

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

MEDICAL QUESTIONS (CONTINUED)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of food and food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	Yes	No
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

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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PHYSICAL EXAMINATION

(Physical examination must be performed on or after April 1 by a health care professional holding an unlimited license to practice medicine, a nurse practitioner or a physician assistant to be valid for the following school year.) Rule 3-10

Name _____ Date of Birth _____ Grade _____ IHSAA Member School _____

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 last 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 use any other appearance/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		Corrected?	Y	N
Height	Weight			
BP	Pulse	Vision	R 20/	L 20/
MEDICAL		NORMAL	ABNORMAL FINDING	
Appearance				
• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVR, aortic insufficiency)				
Eyes/ears/nose/throat				
• Pupils equal				
• Hearing				
Lymphnodes				
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				
• MSV, lesions suggestive of MRSA, tinea corporis				
Neurologic				

MUSCULOSKELETAL		NORMAL	ABNORMAL FINDING	NORMAL	ABNORMAL FINDING
Neck				Knee	
Back				Leg/ankle	
Shoulder/arm				Foot/toes	
Elbow/forearm				Functional	
Wrist/hand/fingers				• Duck-walk, single leg hop	
Hip/thigh					

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
 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 Health Care Professional (print/type) _____ Date _____
 Address _____ Phone _____ License # _____
 Signature of Health Care Professional _____, MD, DO, PA, or NP (Circle one)

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 CSJET 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

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 the 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, illness and even death, is a possible result of 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, illness 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 participation 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.
Unified Sports: Unified Flag Football, Unified Track & Field
- 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, illness and even death, is a possible result of 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:

- The student has adequate family insurance coverage. The student does not have insurance
 The student has football insurance through school.

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
DEC 6/10/2022

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

g:\pr\trng\forms\schools\2022-23\PhysicalForm\2022physicalform.pdf



Reid Health

Sports Medicine

REID HEALTH CONSENT FOR TREATMENT, HEALTH CARE OPERATIONS AND AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FOR THE SCHOOL YEAR 2022-23.

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. This includes anything that occurs at the school or inside Reid Health's Athletic Training Clinic
- 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 Health 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 Health may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) Reid Health 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 31st 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 Health's Sports Medicine Outreach 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.reidhealth.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 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 HEALTH SPORTS MEDICINE ATHLETE DEMOGRAPHICS FORM

Full Legal Name: _____ Preferred Name: _____
 Gender: Male / Female DOB: ____ / ____ / ____ Incoming Grade: 5th 6th 7th 8th Fr. So. Jr. Sr.
 Sports: Fall: _____ Winter: _____ Spring: _____ Additional: _____
 Home Address: _____ City: _____ State: _____ Zip: _____
 Secondary Address: _____ City: _____ State: _____ Zip: _____

Student's Cell #: () _____ Parent's Cell #: () _____ Landline: () _____

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

	Contact Name	Relation	Primary Phone #	Secondary Phone #
1			<input type="checkbox"/> ()	<input type="checkbox"/> ()
2			<input type="checkbox"/> ()	<input type="checkbox"/> ()
3			<input type="checkbox"/> ()	<input type="checkbox"/> ()
4			<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 Requiring Emergency Medical Attention (ex: asthma, food, stings, diabetic, etc.) _____

Do you carry any medical devices (ex: inhaler, EpiPen, insulin pump, heart monitor, etc.) Yes / No
 If so, please list: _____

Important Medical Alerts: _____

Regular Medications: _____

Do you have medical insurance: Yes / No

Primary Insurance Provider _____ Policy # _____ Group # _____ Policy Holder _____

Secondary Insurance Provider _____ Policy # _____ Group # _____ Policy Holder _____

Preferred Hospital Emergency Dept. _____

AUTHORIZATION FOR PHOTOGRAPHY/VIDEOTAPING/AUDIOTAPING/INTERVIEWING

Name	Phone Number
Address	Date of Birth
City, State, Zip	If applicable -- Other Identifier (SSN)

I hereby authorize **REID HEALTH** to complete or arrange the following (Please check all that apply):

Taking photographs, videotaped images, or other images of the following:

- For an online or print gallery of my before and after appointment.
- Conducting an interview and taking written notes
- Making audio recordings of the interview

For the following purposes:

- Reid Health Marketing or Publicity Purposes
- Interviews with News Media
- Educational Purposes
- Other _____

I understand the photographs, audiotapes, videotapes or interviews taken for marketing or publicity purposes may be used for publications and/or broadcast by the media, for public affairs purposes, including publications, advertisements, displays and/or placement on Reid Health's website. I further understand that if used on the Internet, this is a public domain and any electronic transfer is out of the control of Reid Health. I hereby waive all rights that I may have to any claims for payment or royalties in connection with the use of these photographs, audiotapes, videotapes and interviews, and agree that these shall at all times be the property of Reid Health or the media representative present.

I hereby release Reid Health and all employees or agents from liability, including any claims for libel or invasion of privacy, directly or indirectly connected with, arising out of, or resulting from, the taking and authorized use of these photographs, audiotapes, videotapes and interviews.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE AUTHORIZATION. THAT ALL BLANKS OR STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN PRIOR TO THE TIME OF MY SIGNATURE. I HAVE BEEN GIVEN A CHANCE TO ASK QUESTIONS AND EXPLANATIONS ARE UNDERSTOOD BY ME. THIS AUTHORIZATION IS GIVEN FREELY, VOLUNTARILY, AND WITHOUT RESERVATION.

Signature (if eighteen year or older and appropriate)	Date / Time
Witness to Signature: (Signature / Title)	Date / Time

****Signature of family member (parent or guardian) is necessary if person is under eighteen (18) years of age and not an emancipated minor or person is unconscious, or otherwise not competent to give consent.**

_____ is unable to consent because: _____

Legally Responsible Person: (Signature / Title)	Date / Time
Witness to Signature: (Signature / Title)	Date / Time

Reid Health
 Richmond, IN 47374 (765) 983-3000 Room: _____

**CONSENT FOR PHOTOGRAPH/VIDEOTAPING/
 AUDIOTAPING/INTERVIEWING**

CS4040



PATIENT LABEL

**CENTERVILLE-ABINGTON COMMUNITY SCHOOLS 2022-23
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

**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.

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)

SUDDEN CARDIAC ARREST

A Fact Sheet for Student Athletes

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
- Faching 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

Developed and reviewed by the Indiana Department of Education's Sudden Cardiac Arrest Advisory Board (7-7-13)

SUDDEN CARDIAC ARREST

A Fact Sheet for Parents

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*

Developed and reviewed by the Indiana Department of Education's Sudden Cardiac Arrest Advisory Board (7-7-13)

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

A FACT SHEET FOR High School Parents



This sheet has information to help protect your teens from concussion or other serious brain injury.

What is a Concussion?

A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move rapidly back and forth. This sudden movement can cause the brain to bounce around or shift to the right or left, causing chemical changes in the brain and sometimes stretching and damaging the brain cells.

How Can I Help Keep My Teens Safe?

Sports are a great way for teens to stay healthy and have fun. We do what we can to help keep your teen's chances of getting a concussion or other serious brain injury as small as possible.

- Help create a culture of safety for the team.
 - Work with their coach to teach ways to lower the chances of getting a concussion.
 - Emphasize the importance of reporting concussions and taking time to recover from one.
 - Encourage that they follow their coach's rules for safety and the rules of the sport.
 - Tell your teens that you expect them to practice good sportsmanship at all times.
- When appropriate, for the sport or activity, teach your teens that they must wear a helmet to lower the chances of the most common types of brain or head injury. There is no "concession-proof" helmet. Even with helmets, it is important for teens to avoid hits to the head.

How Can I Spot a Possible Concussion?

There are clear or repeatable signs of the common symptoms listed below—or simply say that just "doesn't feel right" after a bump, blow, or jolt to the head or body may be a concussion or other serious brain injury.

Signs Observed by Parents

- Appears dazed or stunned
- Forgetful of instructions, to someone about an assignment or position, or unsure of the game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loss of consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to a crash or hit of fall

Symptoms Reported by Teens

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness, or double or blurry vision
- Blurred or light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Confusion, or concentration or memory problems
- Just not "feeling right" or "feeling slow"

Talk with your teens about concussion, yet there to report their concussion symptoms to you and their coach right away. Some teens think concussions aren't serious or worry that if they report a concussion they will lose their position on the team or look weak. Remind them that it's better to miss one game than the whole season.

GOOD TEAMMATES KNOW:
IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON.



CONCUSSIONS AFFECT EACH TEEN DIFFERENTLY.

While most teens with a concussion feel better within a couple of weeks, some will have symptoms for months or longer. Talk with your teen's healthcare provider if their concussion symptoms do not go away or if they get worse after they return to their regular activities.

Plan ahead. Visit www.cdc.gov/HEADSUP to learn about concussions.

What Are Some More Serious Danger Signs to Look Out For?

In rare cases, a dangerous collection of blood (hematoma) may form on the brain after a bump, blow, or jolt to the head or body and can squeeze the brain against the skull. Call 911 or the poison line in the emergency department right away if, after a bump, blow, or jolt to the head or body, he or she has one or more of these danger signs:

- One pupil larger than the other
- Drowsiness or inability to wake up
- A headache that gets worse and does not go away
- Slurred speech, weakness, numbness, or decreased coordination
- Repeated vomiting or nausea, convulsions or seizure (shaking or twitching)
- Unusual behavior, loss of consciousness, restlessness, or agitation
- Loss of consciousness (passed out/blacked out). Even a brief loss of consciousness should be taken seriously.

Teens who continue to play while having concussion symptoms or who return to play too soon—while the brain is still healing—have a greater chance of getting another concussion. A repeat concussion that occurs while the brain is still healing from the first injury can be very serious, and can affect a teen for a lifetime. It can even be fatal.

What Should I Do If My Teen Has a Possible Concussion?

As a parent, if you think your teen may have a concussion, you should:

1. Remove your teen from play.
2. Stop your teen out of play the day of the injury. Now you should be seen by a healthcare provider or medical team familiar with protocols from a healthcare provider who is experienced in evaluating for concussion.

3. Ask your teen's health care provider for written instructions on helping your teen return to school. You can give the instructions to you or your school nurse and teacher(s) and return to play instructions to the coach and/or athletic trainer.

Do not try to judge the severity of the injury yourself. Only a healthcare provider should assess a teen for a possible concussion. You may not know how to judge the concussion is at all, and some concussions may not show up for hours or days. A teen's return to school and sports should be a gradual process that is carefully managed and monitored by a healthcare provider.

Revised August 2019



A FACT SHEET FOR High School Athletes



This sheet has information to help you protect yourself from concussion or other serious brain injury and know what to do if a concussion occurs.

WHAT IS A CONCUSSION?

A concussion is a brain injury that affects how your brain works. It can happen when your brain gets bounced around in your skull after a fall or hit to the head.

What Should I Do if I Think I Have a Concussion?



Get Checked Out. If you think you have a concussion, do not return to play on the day of the injury. Only a healthcare provider can tell whether you have a concussion and when it is OK to return to school and play. The sooner you get checked out, the sooner you may be able to safely return to play.

Give Your Brain Time to Heal. A concussion can make everyday activities, such as going to school, harder. You may need extra help getting back to your normal activities. Be sure to update your parents and doctor about how you are feeling.

Report It. Tell your coach, parent, and athletic trainer if you think you or one of your teammates may have a concussion. It's up to you to report your symptoms. Your coach and team are relying on you. Plus, you won't play your best if you are not feeling well.

Why Should I Tell My Coach and Parent About My Symptoms?

- Playing or practicing with a concussion is dangerous and can lead to a long recovery.
- While your brain is still healing, you are much more likely to have another concussion. This can put you at risk for a more serious injury to your brain and can even be fatal.

GOOD TEAMMATES KNOW:
IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON.



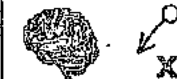
How Can I Tell if I Have a Concussion?

You may have a concussion if you have any of these symptoms after a bump, blow, or jolt to the head or body:

- Get a headache
- Feel dizzy, sluggish, or foggy
- Are bothered by light or noise
- Have double or blurry vision
- Vomit or feel sick to your stomach
- Have trouble focusing or problems remembering
- Feel more emotional or "down"
- Feel confused
- Have problems with sleep

Concussion symptoms usually show up right away, but you might not notice that something "isn't right" for hours or days. A concussion feels different to each person, so it is important to tell your parents and doctor how you are feeling.

How Can I Help My Team?



Protect Your Brain. Avoid hits to the head and follow the rules for safe and fair play to lower your chances of getting a concussion. Ask your coaches for more tips.



Be a Team Player. You play an important role as part of a team. Encourage your teammates to report their symptoms and help them feel comfortable taking the time they need to get better.

The information provided in this document is for informational purposes only and is not intended to be a substitute for professional medical advice. Always seek the advice of your physician or other qualified health provider.

Revised August 2019

