

WOODBIDGE
PERMISSION TO PARTICIPATE

PLEASE PRINT

STUDENT NAME: _____ PHONE NUMBER: _____

ADDRESS: _____ EMERGENCY NUMBER: _____

_____ DATE OF BIRTH: _____

CONTACT PERSON: _____ GRADE: _____

_____ has my permission to participate in all the interscholastic
(Name of athlete) sports **not checked below**.

NOTE- If you check any sport below the athlete will <u>NOT</u> be permitted to participate in that sport.									
<input type="checkbox"/>	Baseball	<input type="checkbox"/>	Basketball	<input type="checkbox"/>	Cheerleading	<input type="checkbox"/>	Cross Country	<input type="checkbox"/>	Crew
<input type="checkbox"/>	Field Hockey	<input type="checkbox"/>	Football	<input type="checkbox"/>	Golf	<input type="checkbox"/>	Ice Hockey	<input type="checkbox"/>	Lacrosse (B)
<input type="checkbox"/>	Lacrosse (G)	<input type="checkbox"/>	Soccer	<input type="checkbox"/>	Softball	<input type="checkbox"/>	Squash	<input type="checkbox"/>	Swimming
<input type="checkbox"/>	Tennis	<input type="checkbox"/>	Track	<input type="checkbox"/>	Volleyball	<input type="checkbox"/>	Wrestling	<input type="checkbox"/>	

I have read and discussed with _____ the attached list of items to protect against loss of athletic eligibility and will retain that page for my reference. I am aware that an injury or even serious injury can occur as a result of participation in interscholastic athletics.

_____ I am the parent of the above student who resides with me in the Woodbridge School District.

NAME: _____

ADDRESS: _____

Signature: _____

_____ I am the court appointed guardian of the above named student who resides with me in the Woodbridge School District.

NAME: _____

ADDRESS: _____

Signature: _____

Health/Accident Insurance Company: _____

Policy Holder: _____ Policy Number: _____

Date: _____ Parent/Guardian Signature: _____

DELAWARE INTERSCHOLASTIC ATHLETIC ASSOCIATION

Parents/Guardian: The DIAA pre-participation physical evaluation and consents form consist of seven pages. Pages one, two and four require your signature while pages five, six and seven are references for you to keep. Page three requires the exam date and physician's signature. Pages three and four require the clearance to participate date and physician's signature. The student must be cleared to participate on or after April 1 based on a physical examination conducted within 12 months of the signature. The clearance is valid through June 30 of the following school year.

Athlete: _____ Phone: _____ School: _____

Age: _____ Gender: _____ Date of Birth: _____ Grade: _____

Parent/Guardian Name: (Please Print: _____)

PARENT/GUARDIAN/STUDENT CONSENTS

_____ Has my permission to participate in all interscholastic sports **NOT checked below?**
(Name of Athlete)

NOTE- If you check any sport below the athlete will NOT be permitted to participate in that sport.							
Baseball		Basketball		Cheerleading		Cross Country	Crew
Field Hockey		Football		Golf		Ice Hockey	Lacrosse (B)
Lacrosse (G)		Soccer		Softball		Squash	Swimming
Tennis		Track		Volleyball		Wrestling	

- My permission extends to all interscholastic activities whether conducted on or off school premises. I have read and discussed the **Parent/Player Concussion Information Form; Symptoms and Risk Factor for Sudden Cardiac Arrest form;** and the list of items that protect against the loss of athletic eligibility, with said participant and I will retain those pages for my reference. I have also discussed with him/her and we understand that physical injury, including paralysis, coma or death can occur as a result of participation in interscholastic athletics. I waive any claim for injury or damage incurred by said participant while participating in the activities NOT checked above.

Parent Signature: _____ **Date:** _____

Student Signature: _____ **Date:** _____

- To enable DIAA and its full and associate member schools to determine whether herein named student is eligible to participate in interscholastic athletics, I hereby consent to the release of any and all portions of school record files, beginning with the sixth grade, of the herein named student, including but not limited to, birth and age records, name and residence of student's parent(s), guardian(s) or Relative Care Giver, residence of student, health records, academic work completed, grades received and attendance records.

Parent Signature: _____ **Date:** _____

- I further consent to DIAA's and its full and associate member schools use of the herein named student's name, likeness, and athletically related information in reports of interscholastic practices, scrimmages or contests, promotional literature of the association, and other materials and releases related to interscholastic athletics.

Parent Signature: _____ **Date:** _____

- By this signature, I hereby consent to allow the physician(s) and other health care provider(s) selected by myself or the schools to perform a pre-participation examination on my child and to provide treatment for any injury received while participating in or training for athletics for his/her school. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation, with coaches, medical staff, Delaware Interscholastic Athletic Association, and other school personnel as deemed necessary. Such information may be used for injury surveillance purposes.

Parent Signature: _____ **Date:** _____

- By this signature, I agree to notify the physician and school of any health changes during the school year that could impact participation in interscholastic athletics.

Parent Signature: _____ **Date:** _____

Preparticipation Physical Evaluation HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician.)

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?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	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?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	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?		
BONE AND JOINT QUESTIONS	Yes	No	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 allantoaxial 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?			FEMALES ONLY		
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 _____

Preparticipation Physical Evaluation PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP / (/)	Pulse	Vision R 20/	L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) ^b			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic ^c			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
^bConsider GU exam if in private setting. Having third party present is recommended.
^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
- Not cleared
- Pending further evaluation
 - For any sports
 - For certain sports _____
- Reason _____

Recommendations _____

I have examined the above-named student and completed the 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).

Health Care Provider: Print/type Name _____ Signature _____, MD, DO, PA, or NP

Address _____ Phone _____

Date of Exam: _____ Date Cleared to Participate: _____

SCHOOL ATHLETE MEDICAL CARD

(Parent/Guardian: please print and complete Sections 1, 2 & 3)

Section 1: CONTACT/PERSONAL INFORMATION

NAME: _____ SPORT(S): _____
AGE: _____ GRADE: _____ BIRTH DATE: _____ GUARDIAN NAME: _____
ADDRESS: _____
PHONE: (H) _____ (W) _____ (C) _____ (P) _____

Other authorized person to contact in case of emergency:

NAME: _____ PHONE(S): _____
NAME: _____ PHONE(S): _____

Preference of Physician (and permission to contact if needed):

NAME: _____ PHONE: _____
HOSPITAL PREFERENCE: _____ INSURANCE: _____
POLICY #: _____ GROUP: _____ PHONE: _____

Section 2: MEDICAL INFORMATION

MEDICAL ILLNESSES: _____
LAST TETANUS (mo/yr): _____ ALLERGIES: _____
MEDICATIONS: _____
(any medications that may be taken during competition require a physician's note)
PREVIOUS HEAD/NECK/BACK INJURY: _____
HEAT DISORDER, OR SICKLE CELL TRAIT: _____
PREVIOUS SIGNIFICANT INJURIES: _____
ANY OTHER IMPORTANT MEDICAL INFORMATION: _____

Section 3: Consent for Athletic Conditioning, Training and Health Care Procedures

I hereby give consent for my child to participate in the school's athletic conditioning and training program, and to receive any necessary healthcare treatment including first aid, diagnostic procedures, and medical treatment, that may be provided by the treating physicians, nurses, athletic trainers, or other healthcare providers employed directly or through a contract by the school, or the opposing team's school. The healthcare providers have my permission to release my child's medical information to other healthcare practitioners and school officials. In the event I cannot be reached in an emergency I give permission for my child to be transported to receive necessary treatment. I understand that Delaware Interscholastic Athletic Association or its associates may request information regarding the athlete's health status, and I hereby give my permission for the release of this information as long as the information does not personally identify my child.

Parent/Guardian Signature: _____ Date: _____
Athlete's Signature: _____ Date: _____

Section 4: Clearance for Participation

Cleared without restrictions Cleared with the following restrictions:

Health Care Provider's Signature: _____ MD/DO, PA, NP Date: _____

For office use only: This card is valid from April 1, 20 _____ through June 30, 20 _____

Note: If any changes occur, a new card should be completed by the parent/guardian. The original card should be kept on file in the school athletic director's or athletic trainer's office. A copy should be kept in the sports' athletic kits. This card contains personal medical information and should be treated as confidential by the school, its employees, agents, and contractors.

Name of School: _____ Name of ATC: _____

WOODBRIIDGE HIGH SCHOOL TRANSPORTATION PERMISSION FORM

PARENTAL RELEASE

STUDENT'S NAME: _____

You and your child acknowledge that the Woodbridge School District has transportation available to after-school practices, located at the Woodbridge Road Athletic Complex, and is willing and able to transport the child to after school practices.

You and your child fully realize and appreciate the risk and danger in allowing your child to drive to and/or from sports practices or to and/from drop-off points along the route with his/her parents, another student's parents, himself/herself or with another student.

PLEASE CHECK THE APPROPRIATE BOX(ES):

- Our son/daughter has our permission to drive to and/or from school sports practices.

- Our son/daughter has our permission to ride in a vehicle driven by another student or another parent to and/or from school sports practices.

- Our son/daughter only has permission to ride the Woodbridge shuttle bus.

We agree that Woodbridge School District assumes no responsibilities as to any trips made in such vehicles other than the Woodbridge shuttle bus and we indemnify and hold it harmless from any claim or liability asserted by him/her or on his/her behalf arising out of the use of any such vehicles and trips.

Parent's Signature

Date

Student's Signature

Date

Asthma Action Plan



General Information:

Name _____
 Emergency contact _____ Phone numbers _____
 Physician/healthcare provider _____ Phone numbers _____
 Physician signature _____ Date _____

Severity Classification	Triggers	Exercise
<input type="radio"/> Intermittent <input type="radio"/> Moderate Persistent <input type="radio"/> Mild Persistent <input type="radio"/> Severe Persistent	<input type="radio"/> Colds <input type="radio"/> Smoke <input type="radio"/> Weather <input type="radio"/> Exercise <input type="radio"/> Dust <input type="radio"/> Air Pollution <input type="radio"/> Animals <input type="radio"/> Food <input type="radio"/> Other _____	1. Premedication (how much and when) _____ 2. Exercise modifications _____

Green Zone: Doing Well

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps well at night

Peak Flow Meter

More than 80% of personal best or _____

Peak Flow Meter Personal Best = _____

Control Medications:

Medicine	How Much to Take	When to Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yellow Zone: Getting Worse

Symptoms

- Some problems breathing
- Cough, wheeze, or chest tight
- Problems working or playing
- Wake at night

Peak Flow Meter

Between 50% and 80% of personal best or _____ to _____

Contact physician if using quick relief more than 2 times per week.

Continue control medicines and add:

Medicine	How Much to Take	When to Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN

- Take quick-relief medication every 4 hours for 1 to 2 days.
- Change your long-term control medicine by _____
- Contact your physician for follow-up care.

IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN

- Take quick-relief treatment again.
- Change your long-term control medicine by _____
- Call your physician/Healthcare provider within _____ hour(s) of modifying your medication routine.

Red Zone: Medical Alert

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Peak Flow Meter

Less than 50% of personal best or _____ to _____

Ambulance/Emergency Phone Number: _____

Continue control medicines and add:

Medicine	How Much to Take	When to Take It
_____	_____	_____
_____	_____	_____
_____	_____	_____

Go to the hospital or call for an ambulance if:

- Still in the red zone after 15 minutes.
- You have not been able to reach your physician/healthcare provider for help.
- _____

Call an ambulance immediately if the following danger signs are present:

- Trouble walking/talking due to shortness of breath.
- Lips or fingernails are blue.

PROTECT YOUR ATHLETIC ELIGIBILITY

YOU ARE NOT ELIGIBLE:

1. If you attend a high school and become 19 years of age before June 15 immediately preceding that school year. (Reg. 1009.2.1.1)
2. If you attend a junior high/middle school that terminates in the 8th grade and become 15 years of age before June 15 immediately preceding that school year. (Reg. 1008.2.1.1.1)
- *3. If you are not legally enrolled at the school which you represent. (Reg. 1008.2.3.1 and Reg. 1009.2.3.1)
4. If you are not residing with your custodial parent(s), court appointed legal guardian(s), Relative Caregiver, or are a student 18 years of age or older and living in the attendance zone of the school you attend unless you are participating in the Delaware School Choice Program, attend a private school or are a boarding school student. **IF YOUR CUSTODIAL PARENT(S), LEGAL GUARDIAN(S) OR RELATIVE CAREGIVER(S) RELOCATES TO A DIFFERENT ATTENDANCE ZONE, YOU MUST NOTIFY YOUR ATHLETIC DIRECTOR IMMEDIATELY.** (Reg. 1008.2.2.1 and Reg. 1009.2.2.1)
- *5. *If you were absent unexcused or absent due to illness or injury; have been suspended (in-school or out-of-school); or have been assigned to homebound instruction or an alternative school for disciplinary reasons.* (Reg. 1008.2.3.4 and 1008.2.3.5 Reg. 1009.2.3.5 and 1009.2.3.6)
6. If you failed to complete the preceding semester for reasons other than personal illness or injury. (Reg. 1008.2.3.6; Reg. 1009.2.3.7)
- *7. If you do not pursue a regular course of study and pass at least five credits per marking period (equivalent of four credits in junior high/middle school), two credits of which must be in the areas of Mathematics, Science, English, or Social Studies. **IF YOU ARE A SENIOR, YOU MUST PASS ALL COURSES WHICH SATISFY AN UNMET GRADUATION REQUIREMENT.** (Reg. 1008.2.6.; Reg. 1009.2.6.1)
8. A student who has previously participated in interscholastic athletics that transfers more than one time during their first year of eligibility shall be ineligible in any sport for a period of ninety (90) school days commencing with the first day of official attendance in the receiving school. The period of ineligibility shall continue to the next grade/school year until 90 school days have passed.
9. If you transfer after the first day of school of your second year of high school, you are ineligible to participate in any sport you previously participated in for a period of one school year (Reg. 1009.2.4)
10. If you participated in the Delaware School Choice Program during the previous academic year and transferred to your "home school" for the current academic year without completing your two-year commitment or receiving a release from the sending school. (Reg. 1008.2.3.3; Reg. 1009.2.3.4)
11. If you participated in the Delaware School Choice Program during the previous academic year and transferred to another "choice school" for the current academic year unless you are playing a sport not sponsored by the sending school. (Reg. 1008.2.4.6.1; Reg. 1009.2.4.7.1)
12. If you reached the age of majority (18), occupied a residence in a different attendance zone than your custodial parent(s) or court appointed legal guardian(s), and have not been in regular attendance at your receiving school for at least 90 school days unless you are participating in the Delaware School Choice Program and your application was properly submitted prior to your change of residence. (Reg. 1009.2.2.1.7)
13. If you attend a high school and more than four years has elapsed since you first entered 9th grade, or more than five years has elapsed since you just entered 8th grade in schools with 8th grade eligibility for high school sports. (Reg. 1009.2.7.1 and 2.7.2.1)
14. **If you attend a junior high/middle school in which only grades 7-8 are permitted to participate in interscholastic athletics and more than two years has elapsed since you first entered 7th grade. (Reg. 1008.2.7.1)**
15. **If you attend a junior high/middle school in which grades 6-8 are permitted to participate in interscholastic athletics and more than three years has elapsed since you first entered 6th grade. (Reg. 1008.2.7.2)**
16. If you have played on or against a professional team or have accepted cash or a cash equivalent (savings bond, certificate of deposit, etc.); a merchandise item(s) with an aggregate retail value of more than \$150; a merchandise discount; a reduction or waiver of fees; a gift certificate or other valuable consideration for athletic participation. (Reg. 1009.2.5.1.4 and 2.5.1.5)
17. If you have used your athletic status to promote a commercial product or service in an advertisement or personal appearance. (Reg. 1009.2.5.1.7)
18. If you have not received a physical examination from a licensed physician (M.D. or D.O.), a certified nurse practitioner or a certified physician's assistant on or after **April 1** and written consent from your custodial parent(s) or court appointed legal guardian(s) to participate in interscholastic athletics is not on file in the school office. (Reg. 1009.3.1.1.1 and Reg. 1008.3.1.1)
19. If you participate in an all-star game not approved by DIAA before you graduate from high school. (Reg. 1009.5.4)
20. If you are a foreign exchange student not participating in a two-semester program listed by the Council on Standards for International Educational Travel (CSIET). (Reg. 1009.2.8.1.2)
21. If you are an international student not in compliance with all DIAA regulations including Reg. 1009.2.2 residency requirements. (Reg. 1009.2.8.2)

***IF YOU ARE NOT IN COMPLIANCE WITH THESE REQUIREMENTS, YOU MAY NOT TRY-OUT, PRACTICE, SCRIMMAGE OR PLAY IN A GAME.**

NOTE: Consult with your coach, athletic director, or principal for information concerning additional eligibility requirements.



Delaware Interscholastic Athletic Association Parent/ Player Concussion Information Form

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. In other words, even a “ding” or a bump on the head can be serious. You can’t see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:

- | | | |
|------------------|-------------------------|------------------------|
| Headaches | Pressure in head | Nausea or vomiting |
| Neck pain | Balance problems | Dizziness |
| Disturbed vision | Light/noise sensitivity | Sluggish |
| Feeling foggy | Drowsiness | Changes in sleep |
| Amnesia | “Don’t feel right” | Low energy |
| Sadness | Nervousness | Irritability |
| Confusion | Repeating questions | Concentration problems |

Signs observed by teammates, parents and coaches may include:

- | | |
|---|--------------------------|
| Appears dazed | Vacant facial expression |
| Confused about assignment | Forgets plays |
| Unsure of game/score etc | Clumsy |
| Responds slowly | Personality changes |
| Seizures | Behavior changes |
| Loss of consciousness | Uncoordinated |
| Can’t recall events before or after hit | |

What can happen if my child keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one (second impact syndrome). This can lead to prolonged recovery, or even to severe brain swelling with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often under report symptoms of injuries, and concussions are no different. As a result, education of administrators, coaches, parents and students is the key for the student-athlete’s safety.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. You should also inform your child’s coach if you think that your child may have a concussion Remember it is better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

**For current and up-to-date information from the CDC on concussions you can go to:
<http://www.cdc.gov/concussion/HeadsUp/youth.html>**

**For a current update of DIAA policies and procedures on concussions you can go to:
<http://www.doe.k12.de.us/diaa>**

**For a free online training video on concussions you can go to:
<http://nfhslearn.com/>**

All parents and players must sign the signature portion of the PPE indicating they have read and understand the above.



SUDDEN CARDIAC ARREST AWARENESS FORM

Revised August 2013

What is Sudden Cardiac Arrest?

- Occurs suddenly and often without warning.
- An electrical malfunction (short-circuit) causes the bottom chambers of the heart (ventricles) to beat dangerously fast (ventricular tachycardia or fibrillation) and disrupts the pumping ability of the heart.
- The heart cannot pump blood to the brain, lungs and other organs of the body.
- The person loses consciousness (passes out) and has no pulse.
- Death occurs within minutes if not treated immediately.

What causes Sudden Cardiac Arrest?

- Conditions present at birth (inherited and non-inherited heart abnormalities)
- A blow to the chest (Commotio Cordis)
- An infection/inflammation of the heart, usually caused by a virus. (Myocarditis)
- Recreational/Performance-Enhancing drug use.
- Other cardiac & medical conditions/Unknown causes. (Obesity/Idiopathic)

What are the symptoms/warning signs of Sudden Cardiac Arrest?

- Fainting/blackouts (especially during exercise)
- Dizziness
- Unusual fatigue/weakness
- Chest pain
- Shortness of breath
- Nausea/vomiting
- Palpitations (heart is beating unusually fast or skipping beats)
- Family history of sudden cardiac arrest at age < 50

ANY of these symptoms/warning signs may necessitate further evaluation from your physician before returning to practice or a game.

What are ways to screen for Sudden Cardiac Arrest?

- The American Heart Association recommends a pre-participation history and physical including 12 important cardiac elements.
- **The DIAA *Pre-Participation Physical Evaluation – Medical History* form includes ALL 12 of these important cardiac elements and is mandatory annually. Please answer the heart history questions on the student health history section of the DIAA PPE carefully.**
- Additional screening using an electrocardiogram and/or an echocardiogram is readily available to all athletes, but is not mandatory.

Where can one find additional information?

- Contact your primary care physician
- American Heart Association (www.heart.org)
- August Heart (www.augustheart.org)
- Championship Hearts Foundation (www.champhearts.org)
- Cypress ECG Project (www.cypressecgproject.org)
- Parent Heart Watch (www.parentheartwatch.com)