

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

| GENERAL QUESTIONS | Yes | No |
|--|-----|----|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | | |
| 2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____ | | |
| 3. Have you ever spent the night in the hospital? | | |
| 4. Have you ever had surgery? | | |
| HEART HEALTH QUESTIONS ABOUT YOU | Yes | No |
| 5. Have you ever passed out or nearly passed out DURING or AFTER exercise? | | |
| 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| 7. Does your heart ever race or skip beats (irregular beats) during exercise? | | |
| 8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <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: _____ | | |
| 9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) | | |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise? | | |
| 11. Have you ever had an unexplained seizure? | | |
| 12. Do you get more tired or short of breath more quickly than your friends during exercise? | | |
| HEART HEALTH QUESTIONS ABOUT YOUR FAMILY | Yes | No |
| 13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? | | |
| 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? | | |
| 15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? | | |
| 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? | | |
| BONE AND JOINT QUESTIONS | Yes | No |
| 17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? | | |
| 18. Have you ever had any broken or fractured bones or dislocated joints? | | |
| 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? | | |
| 20. Have you ever had a stress fracture? | | |
| 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) | | |
| 22. Do you regularly use a brace, orthotics, or other assistive device? | | |
| 23. Do you have a bone, muscle, or joint injury that bothers you? | | |
| 24. Do any of your joints become painful, swollen, feel warm, or look red? | | |
| 25. Do you have any history of juvenile arthritis or connective tissue disease? | | |

| MEDICAL QUESTIONS | Yes | No |
|---|-----|----|
| 26. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 27. Have you ever used an inhaler or taken asthma medicine? | | |
| 28. Is there anyone in your family who has asthma? | | |
| 29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| 30. Do you have groin pain or a painful bulge or hernia in the groin area? | | |
| 31. Have you had infectious mononucleosis (mono) within the last month? | | |
| 32. Do you have any rashes, pressure sores, or other skin problems? | | |
| 33. Have you had a herpes or MRSA skin infection? | | |
| 34. Have you ever had a head injury or concussion? | | |
| 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | |
| 36. Do you have a history of seizure disorder? | | |
| 37. Do you have headaches with exercise? | | |
| 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | | |
| 39. Have you ever been unable to move your arms or legs after being hit or falling? | | |
| 40. Have you ever become ill while exercising in the heat? | | |
| 41. Do you get frequent muscle cramps when exercising? | | |
| 42. Do you or someone in your family have sickle cell trait or disease? | | |
| 43. Have you had any problems with your eyes or vision? | | |
| 44. Have you had any eye injuries? | | |
| 45. Do you wear glasses or contact lenses? | | |
| 46. Do you wear protective eyewear, such as goggles or a face shield? | | |
| 47. Do you worry about your weight? | | |
| 48. Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 49. Are you on a special diet or do you avoid certain types of foods? | | |
| 50. Have you ever had an eating disorder? | | |
| 51. Do you have any concerns that you would like to discuss with a doctor? | | |
| FEMALES ONLY | | |
| 52. Have you ever had a menstrual period? | | |
| 53. How old were you when you had your first menstrual period? | | |
| 54. How many periods have you had in the last 12 months? | | |

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

This document is only necessary when the individual has a documented special need.

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

| | | |
|--|------------|-----------|
| 1. Type of disability | | |
| 2. Date of disability | | |
| 3. Classification (if available) | | |
| 4. Cause of disability (birth, disease, accident/trauma, other) | | |
| 5. List the sports you are interested in playing | | |
| | Yes | No |
| 6. Do you regularly use a brace, assistive device, or prosthetic? | | |
| 7. Do you use any special brace or assistive device for sports? | | |
| 8. Do you have any rashes, pressure sores, or any other skin problems? | | |
| 9. Do you have a hearing loss? Do you use a hearing aid? | | |
| 10. Do you have a visual impairment? | | |
| 11. Do you use any special devices for bowel or bladder function? | | |
| 12. Do you have burning or discomfort when urinating? | | |
| 13. Have you had autonomic dysreflexia? | | |
| 14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness? | | |
| 15. Do you have muscle spasticity? | | |
| 16. Do you have frequent seizures that cannot be controlled by medication? | | |

Explain "yes" answers here

Please indicate if you have ever had any of the following.

| | Yes | No |
|---|------------|-----------|
| Atlantoaxial instability | | |
| X-ray evaluation for atlantoaxial instability | | |
| Dislocated joints (more than one) | | |
| Easy bleeding | | |
| Enlarged spleen | | |
| Hepatitis | | |
| Osteopenia or osteoporosis | | |
| Difficulty controlling bowel | | |
| Difficulty controlling bladder | | |
| Numbness or tingling in arms or hands | | |
| Numbness or tingling in legs or feet | | |
| Weakness in arms or hands | | |
| Weakness in legs or feet | | |
| Recent change in coordination | | |
| Recent change in ability to walk | | |
| Spina bifida | | |
| Latex allergy | | |

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- 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 ^a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI) | | |
| Pulses • Simultaneous femoral and radial pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only) ^b | | |
| Skin • HSV, lesions suggestive of MRSA, tinea corporis | | |
| Neurologic ^c | | |
| MUSCULOSKELETAL | | |
| Neck | | |
| Back | | |
| Shoulder/arm | | |
| Elbow/forearm | | |
| Wrist/hand/fingers | | |
| Hip/thigh | | |
| Knee | | |
| Leg/ankle | | |
| Foot/toes | | |
| Functional • Duck-walk, single leg hop | | |

^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).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

■ PREPARTICIPATION PHYSICAL EVALUATION

CLEARANCE FORM

This form is for summary use in lieu of the physical exam form and health history form and may be used when HIPAA concerns are present.

Name _____ Sex M F Age _____ Date of birth _____

Cleared for all sports without restriction

Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

Not cleared

Pending further evaluation

For any sports

For certain sports _____

Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____

CONSENT FOR ATHLETIC PARTICIPATION & MEDICAL CARE

*Entire Page Completed By Patient

Athlete Information

Last Name _____ First Name _____ MI _____

Sex: Male Female Grade _____ Age _____ DOB ____/____/____

Allergies _____

Medications _____

Insurance _____ Policy Number _____

Group Number _____ Insurance Phone Number _____

Emergency Contact Information

Home Address _____ (City) _____ (Zip) _____

Home Phone _____ Mother's Cell _____ Father's Cell _____

Mother's Name _____ Work Phone _____

Father's Name _____ Work Phone _____

Another Person to Contact _____

Phone Number _____ Relationship _____

Legal/Parent Consent

I/We hereby give consent for (athlete's name) _____ to represent (name of school) _____ in athletics realizing that such activity involves potential for injury. I/We acknowledge that even with the best coaching, the most advanced equipment, and strict observation of the rules, injuries are still possible. ***On rare occasions these injuries are severe and result in disability, paralysis, and even death. I/We further grant permission to the school and TSSAA, its physicians, athletic trainers, and/or EMT to render aid, treatment, medical, or surgical care deemed reasonably necessary to the health and well being of the student athlete named above during or resulting from participation in athletics.*** By the execution of this consent, the student athlete named above and his/her parent/guardian(s) do hereby consent to screening, examination, and testing of the student athlete during the course of the pre-participation examination by those performing the evaluation, and to the taking of medical history information and the recording of that history and the findings and comments pertaining to the student athlete on the forms attached hereto by those practitioners performing the examination. As parent or legal Guardian, ***I/We remain fully responsible for any legal responsibility which may result from any personal actions taken by the above named student athlete.***

Signature of Athlete

Signature of Parent/Guardian

Date

CONSENTIMIENTO A PARTICIPAR EN ACTIVIDADES ATLETICAS Y RECIBIR CUIDADO
MEDICO SI FUERA NECESASRIO

(Este Consentimiento debe ser completado por el Estudiante-A atleta y sus padres o guardianes.)

Información del Estudiante-A atleta

Apellido _____ Nombre _____ SN _____

Sexo: [] Varón [] Hembra Grado _____ Edad _____ Fecha de Nacimiento ____/____/____

Alergias _____

Medicaciones _____

Seguro Médico _____ Número de la Póliza _____

Número del Grupo _____ Teléfono del Seguro _____

Información del Contacto en Caso de Emergencia

Dirección de Casa _____ (Ciudad) _____

(Código Postal) _____

Teléfono de Casa _____ Celular de la Madre o Guardian _____

Celular del Padre o Guardian _____

Nombre de la Madre o Guardian _____ Teléfono del Trabajo _____

Nombre del Padre o Guardian _____ Teléfono del Trabajo _____

Otra Persona Contacto _____

Número de Teléfono _____ Relación _____

Consentimiento Legal de los Padres o Guardianes

Yo/Nosotros damos nuestro consentimiento para que (nombre del Estudiante-A atleta) _____ pueda representar (nombre de la escuela) _____ en deportes y que yo/nosotros entendemos que esa actividad lleva la posibilidad de sufrir lesiones. Yo/Nosotros sabemos que aún con el mejor entrenamiento, los mejores artículos deportivos, y la observación estricta de las reglas, es posible sufrir lesiones. **En algunas ocasiones, estas lesiones son severas y pueden resueltar en incapacidad, parálisis, y hasta la muerte. Yo/Nosotros damos permiso a la escuela y a TSSAA, sus médicos, entrenadores atléticos, y/o técnicos médicos de emergencias a dar ayuda, tratamiento, cuidado médico o quirúrgico considerados necesarios para la salud y bienestar del Estudiante-A atleta nombrado arriba durante o como resultado de su participación en los deportes.** Al firmar este consentimiento, el Estudiante-A atleta nombrado arriba y sus padres/guardianes consienten a que los profesionales de la salud conduzcan un chequeo, examinación, y pruebas del Estudiante-A atleta durante la examinación pre-participatoria y a obtener la historia médica. Entendemos que los profesionales de la salud que conduzcan estas pruebas y evaluaciones van a anotar los resultados y observaciones en los formularios y records que acompañan este documento. Como padre o guardian , **yo/nosotros entendemos que somos totalmente responsables por cualquier asunto legal que pueda resultar de las acciones personales del Estudiante-A atleta nombrado arriba.**

Firma del Estudiante-A atleta

Firma del Padre/Guardian

Fecha

METROPOLITAN NASHVILLE PUBLIC SCHOOLS

Certificates Approving Athletic Participation

STUDENT NAME _____

PARENT CERTIFICATE OF CONSENT

PARENT OR GUARDIAN PLEASE READ AND SIGN

I hereby give my consent for my son or daughter to participate in the athletic program in TSSAA approved sports sponsored by _____ High School/Middle School. I understand that TSSAA may require the release of student records for participation in TSSAA-regulated athletics and hereby give consent for Metropolitan Nashville Public Schools to release my son's or daughter's records to TSSAA. I further release said school, Metropolitan Nashville Public Schools and their agents, from all liability for injuries received by my son or daughter during, or resulting from this program, whether during practice or in an interschool contest. In addition, I hereby release _____ School, Metropolitan Nashville Public Schools and their agents, from all liability for injuries received by the participant while in route to or from contests which are held at other schools. I acknowledge that some sporting events may be held at or adjacent to a public park or facility, and that the lawful possession of handguns is not permitted during school related activities.

Permission is hereby granted for such initial or emergency medical care as may be available because of injury incurred during athletic team practice or competition.

Signature of Parent/Guardian

I have received, read, and understand the *HELPFUL HINTS AND GUIDELINES FOR PARENTS AND STUDENTS FOR HANDLING HEAT STRESS AND EXERCISE*.

I also understand that an athlete must live in the same school zone where he/she plays sports with his/her legal guardian or receive an emergency hardship approval by the Student Assignment Office before he/she will be allowed to participate in the athletic program at the out-of-zone school.

Signature of Parent/Guardian

INSURANCE CERTIFICATE

My son, or daughter, is covered by adequate insurance.

School Insurance _____ Yes _____ No
(Does **NOT** cover Varsity High School Football)

Special Sr. High Football Policy _____ Yes _____ No
(**DOES** cover Varsity High School Football)

Primary Medical Health and Accident Insurance -- Family Insurance Policy

Name of Company

Subscriber's I.D. No.

Group No.

Social Security No.

Secondary Medical/Health Insurance -- Family Insurance Policy

Name of Company

Subscriber's I.D. No.

Group No.

Social Security No.

Signature of Parent Guardian

Date

HELPFUL HINTS AND GUIDELINES FOR PARENTS AND STUDENTS FOR HANDLING HEAT STRESS AND EXERCISE

- 1) Before being allowed to participate in the first practice session of a sport, the following information must be on file in the principal's office for each participant:
 - a. Written evidence that the student has permission to participate. This must be signed by the parent or guardian.
 - b. Written evidence that the student has passed a physical examination as set forth by District and TSSAA policy.
 - c. Written evidence that the student is covered by a family insurance policy. This statement must list the name of the company and be signed by the parent or guardian. If the student is not covered by a family policy, the student must have the special senior high football policy or the student insurance which covers all middle, ninth and senior high sports except senior high football. Any change in family medical insurance status must be brought to the attention of the appropriate head coach.
 - d. If an athlete goes to an athletic screening examination and is referred to another physician for further evaluation, the parent must provide the coach with written evidence that the student has passed a physical examination and the physician must address the condition for which the student was referred.
- 2) Parents must notify coaches, teachers and administrators of an athlete's medical history and any previous health problems including heat illness problems, trouble sweating, vascular defects, asthma or diabetes, that put an athlete in danger. If an athlete is on medication, coaches and teachers should be notified.
- 3) If an athlete is ill (fever, diarrhea, vomiting, etc.), he/she should not practice. If an athlete has been immunized within the past 48 hours, he/she should not practice.
- 4) Top physical performance can only be achieved by an athlete who is in top physical condition. Athletes who perform their preseason endurance running programs will suffer far less than those who arrive out of shape. It is necessary for an athlete to exercise in the heat if he/she is to become acclimated to it.
- 5) Athletes must have ample fluid replacement before, during and after practice. Check and be sure your son/daughter are drinking plenty of water before and after practice sessions. Avoid drinks that contain caffeine or high sugar content.
- 6) Proper nutrition should be taught and encouraged. Salt tablets are not recommended. Attention must be directed to replacing water to replenish body fluids and maintaining appropriate dietary habits.
- 7) Electrolytes and some fluids can be easily replaced with a balanced diet. Fruit, vegetables, and salads add water and electrolytes to the body. Large quantities of carbohydrates provide the energy so vital to recovery from fatigue. Protein intake should be normal. Fat intake should be low, as fats use up a lot of the body's water to be digested.
- 8) Parents must sign that they have received, read, and understand the "Helpful Hints and Guidelines for Parents and Students for Handling Heat Stress and Exercise." An athlete cannot participate until the parent signs and returns this form to the appropriate coach.

CONCUSSION

INFORMATION AND SIGNATURE FORM FOR STUDENT-ATHLETES & PARENTS/LEGAL GUARDIANS

(Adapted from CDC “Heads Up Concussion in Youth Sports”)

Public Chapter 148, effective January 1, 2014, requires that school and community organizations sponsoring youth athletic activities establish guidelines to inform and educate coaches, youth athletes and other adults involved in youth athletics about the nature, risk and symptoms of concussion/head injury.

Read and keep this page.
Sign and return the signature page.

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow or jolt to the head or body that causes the head and brain to move rapidly back and forth. Even a “ding,” “getting your bell rung” or what seems to be a mild bump or blow to the head can be serious.

Did You Know?

- Most concussions occur *without* loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

WHAT ARE THE SIGNS AND SYMPTOMS OF 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 an athlete reports **one or more** symptoms of concussion listed below after a bump, blow or jolt to the head or body, s/he should be kept out of play the day of the injury and until a health care provider* says s/he is symptom-free and it’s OK to return to play.

| SIGNS OBSERVED BY COACHING STAFF | SYMPTOMS REPORTED BY ATHLETES |
|---|--|
| Appears dazed or stunned | Headache or “pressure” in head |
| Is confused about assignment or position | Nausea or vomiting |
| Forgets an instruction | Balance problems or dizziness |
| Is unsure of game, score or opponent | Double or blurry vision |
| Moves clumsily | Sensitivity to light |
| Answers questions slowly | Sensitivity to noise |
| Loses consciousness, even briefly | Feeling sluggish, hazy, foggy or groggy |
| Shows mood, behavior or personality changes | Concentration or memory problems |
| Can’t recall events <i>prior</i> to hit or fall | Confusion |
| Can’t recall events <i>after</i> hit or fall | Just not “feeling right” or “feeling down” |

*Health care provider means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training

CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention after a bump, blow or jolt to the head or body if s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that not only does not diminish, but gets worse
- Weakness, numbness or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless or agitated
- Has unusual behavior
- Loses consciousness (*even a brief loss of consciousness should be taken seriously*)

WHY SHOULD AN ATHLETE REPORT HIS OR HER SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brains. *They can even be fatal.*

Remember:

Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care provider* says s/he is symptom-free and it's OK to return to play.

Rest is key to helping an athlete recover from a concussion. 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. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

* Health care provider means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training.

Student-athlete & Parent/Legal Guardian Concussion Statement

Must be **signed and returned** to school or community youth athletic activity prior to participation in practice or play.

Student-Athlete Name: _____

Parent/Legal Guardian Name(s): _____

After reading the information sheet, I am aware of the following information:

| Student-Athlete initials | | Parent/Legal Guardian initials |
|--------------------------|--|--------------------------------|
| | A concussion is a brain injury which should be reported to my parents, my coach(es) or a medical professional if one is available. | |
| | A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury. | |
| | I will tell my parents, my coach and/or a medical professional about my injuries and illnesses. | N/A |
| | I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms. | N/A |
| | I will/my child will need written permission from a <i>health care provider*</i> to return to play or practice after a concussion. | |
| | Most concussions take days or weeks to get better. A more serious concussion can last for months or longer. | |
| | After a bump, blow or jolt to the head or body an athlete should receive immediate medical attention if there are any danger signs such as loss of consciousness, repeated vomiting or a headache that gets worse. | |
| | After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before the concussion symptoms go away. | |
| | Sometimes repeat concussion can cause serious and long-lasting problems and even death. | |
| | I have read the concussion symptoms on the Concussion Information Sheet. | |

** Health care provider* means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training

Signature of Student-Athlete

Date

Signature of Parent/Legal guardian

Date

Athlete/Parent/Guardian Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form

What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens, blood stops flowing to the brain and other vital organs. SCA doesn't just happen to adults; it takes the lives of students, too. However, the causes of sudden cardiac arrest in students and adults can be different. A youth athlete's SCA will likely result from an inherited condition, while an adult's SCA may be caused by either inherited or lifestyle issues. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

How common is sudden cardiac arrest in the United States?

SCA is the #1 cause of death for adults in this country. There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year. It is the #1 cause of death for student athletes.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- fainting or seizures during exercise;
- unexplained shortness of breath;
- dizziness;
- extreme fatigue;
- chest pains; or
- racing heart.

These symptoms can be unclear in athletes, since people often confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

What are the risks of practicing or playing after experiencing these symptoms?

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who experience SCA die from it.

Public Chapter 325 – the Sudden Cardiac Arrest Prevention Act

The act is intended to keep youth athletes safe while practicing or playing. The requirements of the act are:

- All youth athletes and their parents or guardians must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.

- The immediate removal of any youth athlete who passes out or faints while participating in an athletic activity, or who exhibits any of the following symptoms:
 - (i) Unexplained shortness of breath;
 - (ii) Chest pains;
 - (iii) Dizziness
 - (iv) Racing heart rate; or
 - (v) Extreme fatigue; and
- Establish as policy that a youth athlete who has been removed from play shall not return to the practice or competition during which the youth athlete experienced symptoms consistent with sudden cardiac arrest
- Before returning to practice or play in an athletic activity, the athlete must be evaluated by a Tennessee licensed medical doctor or an osteopathic physician. Clearance to full or graduated return to practice or play must be in writing.

I have reviewed and understand the symptoms and warning signs of SCA.

Signature of Student-Athlete

Print Student-Athlete's Name Date

Signature of Parent/Guardian

Print Parent/Guardian's Name Date