Ohio High School Athletic Association

PREPARTICIPATION PHYSICAL EVALUATION 2014-2015

HISTORY FORM

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

Date of Exam ______________________________

Name ______________________________ Date of birth ______________

Sex ________ Age ________ Grade __________ School ______________________ Sport(s) ______________

Address ______________________________

Emergency Contact: ______________________________ Relationship ______________

Phone (H) ______________ (W) ______________ (Cell) ______________ (Email) ______________

Medicines and Allergies: Please list the prescription and over-the-counter medicines and supplements (herbal and nutritional-including energy drinks/ protein supplements) 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: Asthma Anemia Diabetes 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: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ 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, arryhthmogenic 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 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)		

BONE AND JOINT QUESTIONS - CONTINUED	Yes	No
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 past month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes (cold sores) or MRSA (staph) 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 headaches, or memory problems?		
36. Do you have a history of seizure disorder or epilepsy?		
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 an eye injury?		
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 gain or lose weight? Has anyone recommended that you do?		
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 Student______________________ Signature of parent/guardian______________________ Date: ____________

The student has family insurance ☐ Yes ☐ No If yes, family insurance company name and policy number: ______________________________

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Ohio High School Athletic Association

PREPARTICIPATION PHYSICAL EVALUATION 2014-2015

THE ATHLETE WITH SPECIAL NEEDS - SUPPLEMENTAL HISTORY FORM

PLEASE COMPLETE ONLY IF YOUR STUDENT HAS SPECIAL NEEDS OR A DISABILITY.

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 a 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 have 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 Student______________________ Signature of parent/guardian______________________ Date: ____________

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Ohio High School Athletic Association

PREPARTICIPATION PHYSICAL EVALUATION 2014-2015

PHYSICAL EXAMINATION FORM

Name ______________________________ Date of birth ______________

PHYSICIAN REMINDERS

1. 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 or use condoms?
   - Do you consume energy drinks?
2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION		DATE OF EXAMINATION
Height	Weight	☐ Male ☐ Female
BP / (/) Pulse	Vision R 20/ L20/	Corrected ☐ Y ☐ 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 the point of maximal impulse (PMI)		
Pulses Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional Duck walk, single leg hop		

[a]Consider ECG, echocardiogram, or referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third part present is recommended.
[c]Consider cognitive or baseline neuropsychiatric testing if a history of significant concussion.

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PREPARTICIPATION PHYSICAL EVALUATION 2014-2015

CLEARANCE FORM

Note: Authorization forms (pages 5 and 6) must be signed by both the parent/guardian and the student.

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 student 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. In the event that the examination is conducted en masse at the school, the school administrator shall retain a copy of the PPE. If conditions arise after the student 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 or medical examiner (print/type) ____________________ Date of Exam ____________

Address ____________________ Phone ____________

Signature of physician/medical examiner ____________________, MD, DO, D.C., P.A. or A.N.P.

EMERGENCY INFORMATION

Personal Physician ____________________ Phone ____________

In case of Emergency, contact ____________________ Phone ____________

Allergies ____________________

Other Information ____________________

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THE STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE SCHOOL

OHSAA AUTHORIZATION FORM 2014-2015

I hereby authorize the release and disclosure of the personal health information of ____________________ ("Student"), as described below, to ____________________ ("School").

The information described below may be released to the School principal or assistant principal, athletic director, coach, athletic trainer, physical education teacher, school nurse or other member of the School's administrative staff as necessary to evaluate the Student's eligibility to participate in school sponsored activities, including but not limited to interscholastic sports programs, physical education classes or other classroom activities.

Personal health information of the Student which may be released and disclosed includes records of physical examinations performed to determine the Student's eligibility to participate in school sponsored activities, including but not limited to the Pre-participation Evaluation form or other similar document required by the School prior to determining eligibility of the Student to participate in classroom or other School sponsored activities; records of the evaluation, diagnosis and treatment of injuries which the Student incurred while engaging in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in school sponsored activities.

The personal health information described above may be released or disclosed to the School by the Student's personal physician or physicians; a physician or other health care professional retained by the School to perform physical examinations to determine the Student's eligibility to participate in certain school sponsored activities or to provide treatment to students injured while participating in such activities, whether or not such physicians or other health care professionals are paid for their services or volunteer their time to the School; or any other EMT, hospital, physician or other health care professional who evaluates, diagnoses or treats an injury or other condition incurred by the student while participating in school sponsored activities.

I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored and classroom activities, and that the School is a not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the School is covered under the federal regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.

I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student's participation in certain school sponsored activities may be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to the school principal (or designee) whose name and address appears below.

Name of Principal: ____________________

School Address: ____________________

This authorization will expire when the student is no longer enrolled as a student at the school.

NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS AUTHORIZATION PERSONALLY.

____

Student's Signature | Birth date of Student, including year

____

Name of Student's personal representative, if applicable

I am the Student's (check one): _______ Parent _______ Legal Guardian (documentation must be provided)

____

Signature of Student's personal representative, if applicable | Date

A copy of this signed form has been provided to the student or his/her personal representative

EMERGENCY MEDICAL AUTHORIZATION

Reading Community Schools

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Student ____________________

Address ____________________

Home Phone ____________________

School ____________________

Part I (Complete this section only if you wish to grant consent)

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the designated preferred physician or dentist, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to preferred hospital or any hospital reasonably accessible.

Residential Parent or Guardian

Mother ________ Home Phone ________ Work Phone ________

Father ________ Home Phone ________ Work Phone ________

Other Contact ________ Home Phone ________ Work Phone ________

Address ________ Relationship ________

Other Contact ________ Home Phone ________ Work Phone ________

Address ________ Relationship ________

Preferred Doctor ________ Phone ________

Address ________

Preferred Dentist ________ Phone ________

Address ________

Preferred Local Hospital ________ Phone ________

The authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to performance of such surgery. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physicians should be alerted:

____

____

Parent Signature ________ Date ________

Part II (Complete this section only if you wish to refuse consent)

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

____

Parent Signature ________ Date ________

Complete either Part I or II – Do not fill out both parts.

SIGNATURES PAGE

Student Name: ______________________________

Substance Abuse Policy

As an athlete at Reading Jr./Sr. High School, I realize the dangers that are associated with the use of drugs, alcohol, and tobacco. As an athlete it is my duty and responsibility to be mentally and physically prepared to participate in an athletic contest. Therefore, I pledge not to use drugs, alcohol, or tobacco, and to do everything I can to encourage and help my teammates and fellow students not to use drugs, alcohol, or tobacco. I have also read the Athletic Handbook concerning the Substance Abuse Policy, and I fully understand it and will abide by it.

As the parent(s)/guardian(s) of a Reading Blue Devil athlete, I/we understand the Substance Abuse Policy as outlined in the Athletic Handbook and pledge to help my/our son/daughter remain drug, alcohol, and tobacco free.

Insurance

All boys and girls participating in an extracurricular activity for Reading Community Schools are required to carry insurance to cover possible injury. My son/daughter is fully covered by accident and health insurance carried by our family. In the event of injury to our son/daughter through extracurricular activities, I shall in no way hold the Reading Community School District responsible for said injury. Our family will assume complete coverage of the injury.

Possible Hazards

I/WE as parent(s)/guardian(s) do hereby acknowledge that I/we have been fully advised, cautioned, and warned by the proper administrative and coaching personnel of the reading Community Schools that my/our children may suffer injury, including but not limited to sprains, fractures, brain damage, paralysis or even death, by participating in sports. Notwithstanding such warnings, and with full knowledge of the risk of serious injury to my/our child named above which may result, I/We give our consent for our son/daughter to participate in the sports.

As a student athlete I understand that participation in all sports requires an acceptance of risk of possible injury. I will help make the game safer by not intentionally using techniques which are illegal and which can cause serious injury.

Athletic Handbook Notification

I/We parent(s)/guardian(s) have seen and reviewed the Reading Jr./Sr. High School Athletic Handbook. The athlete's signature indicates that he/she is accepting the responsibilities of participating in extracurricular activities at the Reading Jr./Sr. High School. Likewise, a parent or guardian's signature indicates they are aware of the athlete's acceptance.

HIPPA

In the event of injury to my child, I authorize the release of medical information to the coaching, teaching, and/or administrative staff for the period of July 1, 20 __ to July 1, 20 __. My signature below authorizes the release of medical information (verbally or in writing) necessary to facilitate treatment. My signature also gives permission to the staff of Orthopaedic Physical Therapy Associates, Inc. to obtain (verbally or in writing) if necessary to facilitate treatment. My signature below confirms that I have received the Privacy Policy Notice and understand that a unique relationship exists between the athletic trainer, student, and staff of Reading Community Schools and the medical information must be exchanged so that the appropriate level of participation can be established.

Release

We, the undersigned, student and parent(s)/guardian(s) hereby release, waive, discharge, and covenant not to sue Reading School District, Board of Education members, superintendent, principals, administrators, employees, agents, or anyone action on its behalf, from any and all liability, claim, demand, action or cause of action, of whatever kind of nature, either in law or equity, arising from or by reason of any bodily injury, personal injury or mental injury, known or unknown, including death, resulting from, or to result from our son's/daughter's participation in any extracurricular activity on behalf of or in the name of the Reading School District Board of Education. We hereby assume full responsibility for and risk of bodily injury, personal injury or mental injury or death due to his/her participation in sports and/or other extracurricular activities on behalf of or in the name of the Reading School District Board of Education.

We expressly agree that this is intended to be as broad and inclusive as permitted by the laws of the State of Ohio or any other state in which said student may be injured and that if any portion of this release is held invalid, it is agreed that the balance shall, nevertheless, continue in full force and effect. We further state that I/we have carefully read the above release and know the concerns of same and sign this release as our own free act.

Transportation Waiver

I hereby grant permission for my son/daughter to be transported by a privately owned car to and from an athletic event. By doing this, I realize that Reading could have provided bus transportation, but instead I elected to send my son/daughter to the athletic event through alternate means. Therefore, I hereby release the Reading Community School District, its transportation services, and all of its personnel from any and all responsibilities for transporting my child.

Student athlete signature: ______________________________ Date: ______________

Parent/Guardian signature: ______________________________ Date: ______________

Parent/Guardian signature: ______________________________ Date: ______________

****Ohio's return-to-play law went into effect on April 26th, 2013****

Ohio's Return-to-Play Law: What Coaches & Referees Need to Know – *Interscholastic Athletics (School sports)*

Training In Recognizing the Signs and Symptoms of a Concussion

COACHES: Those wishing to coach interscholastic athletics, whether done on a paid or volunteer basis, must hold a Pupil Activity Permit (PAP) issued by the Ohio Department of Education.

For Coaches with a Current PAP: Starting April 26th, 2013, in order to renew their PAP (which is required every three years), coaches will be required to present evidence that they have successfully completed:

1) a training program in recognizing the signs and symptoms of concussions and head injuries that is linked on the Department of Health's web site (http://www.healthy.ohio.gov/vipp/concussion)

-OR-

2) a training program authorized and required by an organization that regulates interscholastic conferences or events.

For First-time PAP Applicants: On or after April 26th, 2013, those who apply for a first-time Pupil Activity Permit to coach interscholastic athletics will be required to successfully complete a training program that is specifically focused on concussions as part of the requirements to obtain a permit.

REFEREES: Starting April 26th, 2013, referees for interscholastic athletics must either:

1) hold a Pupil Activity Permit (see above) for coaching interscholastic athletics

-OR-

2) successfully complete, every three years, an online training program in recognizing the signs and symptoms of concussions and head injuries that is linked on the Department of Health's web site (http://www.healthy.ohio.gov/vipp/concussion) or a training program authorized and required by an organization that regulates interscholastic conferences or events.

Online Training

The current, free online trainings that have been approved by ODH to meet the training requirement for coaches and referees are listed on the **ODH website, under Online Concussion Management Training at: http://www.healthy.ohio.gov/vipp/concussion.aspx**. Instructions for completing the trainings and receiving a certificate are also provided on this site.

Ohio's return-to-play law went into effect on April 26th, 2013

Removal From Play

1) Starting April 26th, 2013, coaches or referees must remove an athlete exhibiting the signs and symptoms of a concussion during practice or a game. These include:

- Appears dazed or stunned.
- Is confused about assignment or position.
- Forgets plays.
- Is unsure of game, score or opponent.
- Moves clumsily.
- Answers questions slowly.
- Loses consciousness (even briefly).
- Shows behavior or personality changes (irritability, sadness, nervousness, feeling more emotional).
- Can't recall events before or after hit or fall.
- Any headache or "pressure" in head. (How badly it hurts does not matter.)
- Nausea or vomiting.
- Balance problems or dizziness.
- Double or blurry vision.
- Sensitivity to light and/or noise
- Feeling sluggish, hazy, foggy or groggy.
- Concentration or memory problems.
- Confusion
- Does not "feel right."
- Trouble falling asleep.
- Sleeping more or less than usual.

2) The athlete ***cannot*** return to play on the same day that he or she is removed.

3) The athlete ***is not permitted*** to return to play until they have been assessed and receive written clearance by a physician (MD or DO) or by any other licensed health care provider approved by the school district. It is important to review your school's policy regarding which health care providers are authorized to clear an athlete to return-to-play.

For More Information

Ohio Department of Health – Ohio's Return to Play Law:
http://www.healthy.ohio.gov/vipp/concussion

Centers for Disease Control and Prevention – Heads Up in Youth Sports:
www.cdc.gov/concussion/HeadsUp/youth.html

Ohio Department of Education – Pupil Activity Permit:
http://www.ode.state.oh.us/GD/Templates/Pages/ODE/ODEDetail.aspx?page=3&TopicRelationID=1328&ContentID=84483&Content=126368

Ohio Department of Health Concussion Information Sheet

For Interscholastic Athletics

Dear Parent/Guardian and Athletes,

This information sheet is provided to assist you and your child in recognizing the signs and symptoms of a concussion. Every athlete is different and responds to a brain injury differently, so seek medical attention if you suspect your child has a concussion. Once a concussion occurs, it is very important your athlete return to normal activities slowly, so he/she does not do more damage to his/her brain.

What is a Concussion?

A concussion is an injury to the brain that may be caused by a blow, bump, or jolt to the head. Concussions may also happen after a fall or hit that jars the brain. A blow elsewhere on the body can cause a concussion even if an athlete does not hit his/her head directly. Concussions can range from mild to severe, and athletes can get a concussion even if they are wearing a helmet.

Signs and Symptoms of a Concussion

Athletes do not have to be "knocked out" to have a concussion. In fact, less than 1 out of 10 concussions result in loss of consciousness. Concussion symptoms can develop right away or up to 48 hours after the injury. Ignoring any signs or symptoms of a concussion puts your child's health at risk!

Signs Observed by Parents of Guardians

- *Appears dazed or stunned.*
- *Is confused about assignment or position.*
- *Forgets plays.*
- *Is unsure of game, score or opponent.*
- *Moves clumsily.*
- *Answers questions slowly.*
- *Loses consciousness (even briefly).*
- *Shows behavior or personality changes (irritability, sadness, nervousness, feeling more emotional).*
- *Can't recall events before or after hit or fall.*

Symptoms Reported by Athlete

- *Any headache or "pressure" in head. (How badly it hurts does not matter.)*
- *Nausea or vomiting.*
- *Balance problems or dizziness.*
- *Double or blurry vision.*
- *Sensitivity to light and/or noise*
- *Feeling sluggish, hazy, foggy or groggy.*
- *Concentration or memory problems.*
- *Confusion.*
- *Does not "feel right."*
- *Trouble falling asleep.*
- *Sleeping more or less than usual.*

Be Honest

Encourage your athlete to be honest with you, his/her coach and your health care provider about his/her symptoms. Many young athletes get caught up in the moment and/or feel pressured to return to sports before they are ready. It is better to miss one game than the entire season… or risk permanent damage!

Seek Medical Attention Right Away

Seeking medical attention is an important first step if you suspect or are told your child has a concussion. A qualified health care professional will be able to determine how serious the concussion is and when it is safe for your child to return to sports and other daily activities.

- *No athlete should return to activity on the same day he/she gets a concussion.*
- *Athletes should NEVER return to practices/games if they still have ANY symptoms.*
- *Parents and coaches should never pressure any athlete to return to play.*

The Dangers of Returning Too Soon

Returning to play too early may cause Second Impact Syndrome (SIS) or Post-Concussion Syndrome (PCS). SIS occurs when a second blow to the head happens before an athlete has completely recovered from a concussion. This second impact causes the brain to swell, possibly resulting in brain damage, paralysis, and even death. PCS can occur after a second impact. PCS can result in permanent, long-term concussion symptoms. The risk of SIS and PCS is the reason why no athlete should be allowed to participate in any physical activity before they are cleared by a qualified health care professional.

Recovery

A concussion can affect school, work, and sports. Along with coaches and teachers, the school nurse, athletic trainer, employer, and other school administrators should be aware of the athlete's injury and their roles in helping the child recover.

During the recovery time after a concussion, physical and mental rest are required. A concussion upsets the way the brain normally works and causes it to work longer and harder to complete even simple tasks. Activities that require concentration and focus may make symptoms worse and cause the brain to heal slower. Studies show that children's brains take several weeks to heal following a concussion.

OHIO INJURY PREVENTION
PARTNERSHIP
Child Injury Action Group

www.healthyohioprogram.org/concussion

Returning to Daily Activities

1. Be sure your child gets plenty of rest and enough sleep at night – no late nights. Keep the same bedtime weekdays and weekends.
2. Encourage daytime naps or rest breaks when your child feels tired or worn-out.
3. Limit your child's activities that require a lot of thinking or concentration (including social activities, homework, video games, texting, computer, driving, job-related activities, movies, parties). These activities can slow the brain's recovery.
4. Limit your child's physical activity, especially those activities where another injury or blow to the head may occur.
5. Have your qualified health care professional check your child's symptoms at different times to help guide recovery.

Returning to School

1. Your athlete may need to initially return to school on a limited basis, for example for only half-days, at first. This should be done under the supervision of a qualified health care professional.
2. Inform teacher(s), school counselor or administrator(s) about the injury and symptoms. School personnel should be instructed to watch for:
   - *a. Increased problems paying attention.*
   - *b. Increased problems remembering or learning new information.*
   - *c. Longer time needed to complete tasks or assignments.*
   - *d. Greater irritability and decreased ability to cope with stress.*
   - *e. Symptoms worsen (headache, tiredness) when doing schoolwork.*
3. Be sure your child takes multiple breaks during study time and watch for worsening of symptoms.
4. If your child is still having concussion symptoms, he/she may need extra help with school-related activities. As the symptoms decrease during recovery, the extra help or supports can be removed gradually.

Resources

ODH Violence and Injury Prevention Program
www.healthyohioprogram.org/vipp/injury.aspx

Centers for Disease Control and Prevention
www.cdc.gov/Concussion

National Federation of State High School Associations
www.nfhs.org

Brain Injury Association of America
www.biausa.org/

Returning to Play

1. Returning to play is specific for each person, depending on the sport. *Starting 4/26/13, Ohio law requires written permission from a health care provider before an athlete can return to play.* Follow instructions and guidance provided by a health care professional. It is important that you, your child and your child's coach follow these instructions carefully.
2. Your child should NEVER return to play if he/she still has ANY symptoms. (Be sure that your child does not have any symptoms at rest and while doing any physical activity and/or activities that require a lot of thinking or concentration).
3. Be sure that the athletic trainer, coach and physical education teacher are aware of your child's injury and symptoms.
4. Your athlete should complete a step-by-step exercise -based progression, under the direction of a qualified healthcare professional.
5. A sample activity progression is listed below. Generally, each step should take no less than 24 hours so that your child's full recovery would take about one week once they have no symptoms at rest and with moderate exercise.*

Sample Activity Progression*

***Step 1**: Low levels of non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: walking, light jogging, and easy stationary biking for 20-30 minutes).*

***Step 2**: Moderate, non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: moderate jogging, brief sprint running, moderate stationary biking, light calisthenics, and sport-specific drills without contact or collisions for 30-45 minutes).*

***Step 3**: Heavy, non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: extensive sprint running, high intensity stationary biking, resistance exercise with machines and free weights, more intense non-contact sports specific drills, agility training and jumping drills for 45-60 minutes).*

***Step 4**: Full contact in controlled practice or scrimmage.*

***Step 5**: Full contact in game play.*

***If any symptoms occur, the athlete should drop back to the previous step and try to progress again after a 24 hour rest period.**

Ohio Department of Health
Violence and Injury Prevention Program
246 North High Street, 8th Floor
Columbus, OH 43215
(614) 466-2144

www.healthyohioprogram.org/concussion

Rev. 02.13

Ohio Department of Health Concussion Information Sheet

For Interscholastic Athletics

Acknowledgement of Having Received the "Ohio Department of Health's Concussion and Head Injury Information Sheet"

By signing this form, as the parent/guardian/care-giver of the student-athlete named below, I acknowledge receiving a copy of the concussion and head injury information sheet prepared by the Ohio Department of Health as required by section 3313.539 of the Revised Code.

I understand concussions and other head injuries have serious and possibly long-lasting effects.

By reading the information sheet, I understand I have a responsibility to report any signs or symptoms of a concussion or head injury to coaches, administrators and my student-athlete's doctor.

I also understand that coaches, referees and other officials have a responsibility to protect the health of the student-athletes and may prohibit my student-athlete from further participation in athletic programs until my student-athlete has been cleared to return by a physician or other appropriate health care professional.

____________________________ ____________________________

Athlete Date

____________________________ ____________________________

Parent/Guardian Date

Rev. 02.13

Join the Reading Athletic Boosters

Membership fee: $5.00 individual
$10.00 family

Name: ____

Address: ____

Phone Number: _____________________________________

Individual ________ **Family** ________

The Reading Athletic Boosters main goal is to help defray the costs of our Athletic Department.

Below is a list of the different fundraisers that the Athletic Boosters do. If you are interested in helping in any way, please check the appropriate box below & let us know your availability. You can still join the boosters and do not have to volunteer in any way.

Friday night Home Football games (6:00 to 9:00)
JV Football & Jr. High Football games – times vary
Boys & Girls Home Soccer games – times vary
Girl's Volleyball games – times vary
Boy's & Girl's Basketball games – concession & spirit wear – times vary
Concessions for Boy's & Girl's Baseball (3:30- 6:00)
Track meets – times vary

________No I cannot help in any volunteer work.

________Yes I would like to volunteer. Times available: ________________________

Please make checks payable to: Reading Athletic Boosters & mail to: Noanie Martin, 317 Bradley Avenue, Reading, OH 45215 or send back to school and have the secretary place in the Booster mailbox.

Thank you for your support! Go BLUE DEVILS!