BISHOP McDEVITT
ATHLETIC PHYSICAL
2019-2020 School Year

Parents and Student-Athletes:

1. All athletes must have a physical to participate in the PIAA sanctioned athletic event as required by the PA Department of Health (Physicals by a family Doctor must be dated less than six weeks before the season begins – not on or before June 1st, 2019).
2. Physicals will be given at Bishop McDevitt in our school training room and there will be a $15 charge for the physical. A recertification is free of charge as you are only handing in a form to the athletic office.
3. *Please complete all information in this packet. Parent/Guardian signatures are required in several places. If the packet is not filled out completely, you may not get a physical. No exceptions!
4. All students must have medical insurance. If you do not have adequate coverage please see the athletic director immediately to discuss available options.
5. There is an athletic participation fee at Bishop McDevitt. The fee is $75.00 per athlete for their first sport and $50.00 for a second sport. A third sport is free of charge. Checks should be made payable to: Bishop McDevitt High School, and on the memo line please indicate which sport is being played.
6. Tryouts/First official day of practice begins Monday, November 18th (boys & girls basketball, swimming, wrestling & bowling).

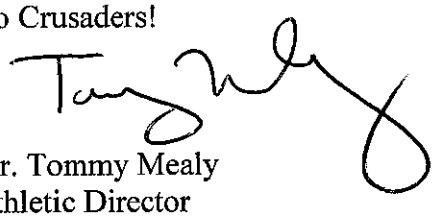
****The athlete should have two (2) checks written to "Bishop McDevitt HS" with them. One is the $75 registration fee and the other is the $15 fee for the physician. The monies go in separate areas and that is why we are asking for two (2) checks. Thank you for your cooperation on that matter.**

Physical Schedule: Monday: November 4th, 2019

Girls 9:30 - 10:15am
Boys 10:15 - 11:00am

Please direct any questions to your respective coaches or the athletic trainer Rochelle Blakley at 717-236-7973 x2360.

Go Crusaders!



Mr. Tommy Mealy
Athletic Director

BISHOP MCDEVITT SPORTS MEDICINE

Dear Parent/Gaurdian,

Bishop McDevitt High School is currently implementing a program for our student-athletes. This program will assist our team physicians/athletic trainer in evaluating and treating head injuries (e.g., concussion.) In order to better manage concussions sustained by our student-athletes, we have acquired a software tool called ImPACT (Immediate Post Concussion Assessment and Cognitive Testing). ImPACT is a computerized exam utilized in many professional, collegiate, and high school programs across the country to successfully diagnose and manage concussions. If an athlete is believed to have suffered a head injury during competition, ImPACT is used to help determine the severity of head injury and when the injury has fully healed.

All athletes are required to take the computerized exam before beginning sport practice or competition. This non-invasive test is set up in "video-game" type format and takes about 15-20 minutes to complete. It is simple, and actually many athletes enjoy the challenge of taking the test. Essentially, the ImPACT test is a preseason physical of the brain. It tracks information such as memory, reaction time, speed, and concentration. It, however, is not an IQ test.

If a concussion is suspected, the athlete will be required to re-take the test. Both the preseason and post-injury test data is given to the approved concussion specialist of your choice to help evaluate the injury. (The list of concussion approved concussion specialists is included at the end of this form). The information gathered can also be shared with your family doctor. The tests data will enable these health professionals to determine when return-to-play is appropriate and safe for the injured athlete. If an injury of this nature occurs to your child, you will be promptly contacted with all the details.

I wish to stress that the ImPACT testing procedures are non-invasive, and they pose no risks to your child. We are excited to implement this program given that it provides us the best available information for managing concussions and preventing potential brain damage that can occur from multiple concussions. The Bishop McDevitt High School administration, coaching, and athletic training staffs are striving to keep your child's health and safety at the forefront of the student athletic experience. Please return the attached page with appropriate signatures. If you have any further questions regarding this program please feel free to contact me at (717) 236-2360 or acusma@bishopmcdevitt.org.

Sincerely,

Aaron Cusma LAT, ATC

Athletic Trainer

BISHOP MCDEVITT SPORTS MEDICINE

ImPACT™

CONSENT FOR COGNITIVE TESTING and RELEASE OF INFORMATION

I give my permission for (name of child) _____

(child's date of birth) _____

to have a post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) administered at Bishop McDevitt High School. I understand that my child may need to be tested more than once, depending upon the results of the test, as compared to my child's baseline test, which is on file at McD. I understand there is no charge for the testing.

Bishop McDevitt High School may release the ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) results to my child's primary care physician, neurologist, or other treating physician, as indicated below.

I understand that general information about the test data may be provided to my child's guidance counselor and teachers, for the purposes of providing temporary academic modifications, if necessary.

Name of parent or guardian: _____

Signature of parent or guardian: _____

Date: _____

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of doctor: _____

Name of practice or group: _____

Phone number: _____

Student's home address: _____

Parent or guardian phone numbers (please indicate preferred contact number & time if necessary):

_____(H) _____(W)

_____(cell)

BISHOP MCDEVITT SPORTS MEDICINE

CONCUSSION INFORMATION

The general assembly of Pennsylvania has passed Senate Bill No. 200 which establishes standards for managing concussions and traumatic brain injuries for student athletes. Students participating in or desiring to participate in athletic activity, their parents, and coaches must be educated about the nature and risk of concussion and traumatic brain injury. A student determined by a game official, coach from the student's team, certified athletic trainer, licensed physician, licensed physical therapist or other official designated by the student's school entity to exhibit signs or symptoms of a concussion or traumatic brain injury while participating in an athletic activity is required to be removed from participation at that time. The student may not return to play until the student is evaluated and cleared for participation by an appropriate medical professional with a background in concussion management.

The purpose of this document is to provide you the information required by law relating to concussions. If you have any questions, please contact the athletic trainer, your Certified Athletic Trainer, at 717-236-7973 Ext. 2360.

What is a concussion?

A **concussion** is a brain injury caused by a bump or blow to the head or body that causes the brain to move rapidly within the skull. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious. You can't see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

Comprehensive Signs/Symptoms for Concussion:

OBSERVED SIGNS

Loss of consciousness (even briefly)
Appears dazed or stunned
Is confused about events
Repeats questions
Answers questions slowly
Cannot recall events PRIOR to hit, bump, fall
Cannot recall events AFTER hit, bump, fall
Shows behavior and/or personality changes
Forgets class schedule/assignments/things to do

COGNITIVE SYMPTOMS

Difficulty thinking clearly
Difficulty concentrating
Feeling more slowed down
Felling sluggish, lazy, hazy, foggy

PHYSICAL SIGNS

Headache or "pressure" in the head
Nausea or vomiting
Balance problems or dizziness
Fatigue or feeling tired
Blurry or double vision
Sensitivity to light
Sensitivity to noise
Numbness or tingling
Does not "feel right"; feels "out of it"

EMOTIONAL SYMPTOMS

Irritable
Sad
More emotional than usual
Nervous/Anxious

Bishop McDevitt Sports Medicine

Concussion Information

What can happen if my child/player plays 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. This can lead to prolonged recovery, or even severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often fail to report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents and students is the key to student-athlete's safety.

If a concussion is suspected:

Seek medical attention right away. A concussion specialist will be able to decide how serious the concussion is and when it is safe for your child to return to sports. Keep your child out of play. Concussions take time to heal. Don't let your child return to play until a concussion specialist says it's OK. Children who return to play too soon—while the brain is still healing—risk a greater chance of having a second concussion. Second or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.

It is OK to:

- Use acetaminophen (Tylenol) for head aches
- Use ice pack on head & neck as needed for comfort
- Eat a light diet
- Go to sleep
- Rest (no strenuous activity or sports)

There is NO need to:

- Check eyes with a flashlight
- Wake up every hour
- Test reflexes
- Stay in bed

Do NOT:

- Drive while symptomatic
- Exercise or lift weights
- Take ibuprofen, aspirin, naproxen or other non-steroidal anti-inflammatory medications

If an athlete is on the field and suspected of having a concussion, he/she is removed immediately from play. The athletic trainer (ATC) will perform an on-field assessment. Once a concussion is confirmed, the ATC will give an informational packet to the parent or guardian containing educational materials and a list of local concussion specialists in the area. During the recovery process, the ATC will work with the physician to safely return the athlete to play using a graduated return-to-play program.

BISHOP MCDEVITT SPORTS MEDICINE

ABBREVIATED CONCUSSION PROTOCOL

In December 2011, the General Assembly of Pennsylvania passed the Safety in Youth Sports Act that establishes "standards for managing concussions and traumatic brain injuries for student athletes." This Act will be effective as of July 1, 2012. The protocol at Bishop McDevitt High School is designed to follow these legislative guidelines and outline the procedures following an injury to an athlete's brain. These procedures are to help insure that injured athletes are identified, treated appropriately by an appropriate medical professional, and are fully recovered prior to returning to play.

There are common signs and symptoms that help with the recognition of a concussion. To see a complete list of these signs and symptoms, please refer to the Take Home Instruction Sheet. If your athlete is experiencing any signs or symptoms after a head injury then he/she should remain home from school until he/she is symptom free without the help of medications for 24 hours.

After your athlete is diagnosed with a concussion, the Athletic Director and School Nurse will be notified of the injury. Your athlete's PE teacher will also be informed because, as a concussed athlete, they should not be participating. After your athlete sees a physician, he/she should bring in a note that reiterates that they should not participate in gym, as well as any other restrictions the physician may provide. If your athlete requires any academic accommodations from his/her physician, he/she should bring this paperwork to the guidance office and athletic trainer.

When an athlete suffers from a head injury, they are taken through a series of neurocognitive tests. A SCAT3 test can be performed immediately after the injury on the sideline or in the Athletic Training Room. The SCAT3 tests for general cognitive function, such as memory, orientation, and balance, and also offers a standardized symptom evaluation that can continue to be utilized throughout your athlete's treatment. The athlete should check in to the Athletic Training Room every day to go through a daily symptom evaluation.

Bishop McDevitt also utilizes ImPACT testing. ImPACT is a computerized assessment that is utilized as a tool to evaluate neurocognitive function recovery after a concussion. The functions assessed include memory, attention, brain processing speed, reaction time and post concussion symptoms. At the beginning of each season, all new athletes are required to take a baseline ImPACT test. Returning athletes are required to take a baseline ImPACT every second year (i.e. freshmen and juniors). After an athlete is concussed, post injury testing ideally will be done within 24-72 hours of the initial injury. Please contact the Athletic Trainer to set up a time for your athlete to take his/her Post-Injury ImPACT test. After the first Post-Injury test, the test will be repeated at the appropriate intervals. These neurocognitive test results are extremely helpful for your physician so it is recommend that you bring them to your appointment. ImPACT is **NOT** a test that will diagnose a concussion, but rather a tool used in the evaluation of concussions and the management of concussion recovery.

BISHOP MCDEVITT SPORTS MEDICINE
ABBREVIATED CONCUSSION PROTOCOL

Return to Play Procedures

If an athlete exhibits any signs or symptoms of a concussion or has any abnormal cognitive testing, he/she will **NOT** be permitted to return to play on the same day of the injury. In order to progress back into activity after a concussion, a concussed athlete must meet **ALL** of the following criteria:

- Asymptomatic at rest without the aid of medications that mask or modify the symptoms of a concussion
- Asymptomatic with mental exertion (athlete must attend a full day of school)
- Within normal range of baseline on Post-Injury ImPACT testing
- Have written clearance from a physician

When all of the above criteria are met, your athlete will be progressed back to full activity following a stepwise process. Progression is individualized and is determined on a case by case basis. Factors such as concussion history, duration and type of symptoms, age, and the type of sports can affect the rate of their progression. The progression consists of six steps as follows:

Rehabilitation Stage	Functional exercise at each stage of rehabilitation	Objective of each stage
1. No activity	Symptom limited physical and cognitive rest.	Recovery
2. Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity <70% maximum permitted heart rate. *No resistance training.*	Increase HR
3. Sport-specific exercise	Skating drills in ice hockey, running drills in soccer. *No head impact activities.*	Add movement
4. Non-contact training drills	Progression to more complex training drills, eg, passing drills in football and ice hockey. May start progressive resistance training.	Exercise, coordination and cognitive load
5. Full-contact practice	Following medical clearance participate in normal training activities.	Restore confidence and assess functional skills by coaching staff
6. Return to play	Normal game play.	

A minimum of 24 hours must occur between each step. If an athlete experiences any symptoms during a step of the progression, they must wait 24 hours after symptoms resolve before restarting their progression at the same step.

The athletic trainer will review appropriate activities for the day with your athlete prior to activity. Your child must report to the athletic trainer for re-assessment **daily** (or for the days that he/she is in school) until he/she has progressed to unrestricted activity and is fully cleared for return to play.

If you have any questions regarding our protocol or if you need to schedule a Post-Injury ImPACT test, please contact the Athletic Trainer.

Athletic Training Room: (717) 236-7973 Ext 2360

Bishop McDevitt High School
Emergency Information Form 2018-2019

GRADE: _____

ATHLETE INFORMATION

Please mark ALL sports in which student will be participating in throughout the entire school year:

___Football	___Girls Soccer	___Girls Tennis	___Boys Soccer	___Cross Country	___Golf
___Boys Basketball	___Girls Basketball	___Swimming	___Cheerleading	___Wrestling	___Bowling
___Track/Field	___Boys Tennis	___Softball	___Baseball	___Field Hockey	___Ice Hockey
___Boys Lacrosse	___Girls Volleyball				

NAME: _____ DATE OF BIRTH _____

ADDRESS _____ PARENTS/GUARDIANS _____ _____

_____ CELL _____ _____

_____ WORK _____ _____

PHONE _____ EMAIL _____

EMERGENCY CONTACTS (To be used if parents cannot be contacted)

1) NAME _____
RELATION _____
HOME _____
CELL _____
WORK _____

2) NAME _____
RELATION _____
HOME _____
CELL _____
WORK _____

3) NAME _____
RELATION _____
HOME _____
CELL _____
WORK _____

MEDICAL CONDITIONS

ALLERGIES ___YES ___NO
LIST: _____
_____
_____

MEDICAL CONDITIONS/CONCERNS:
LIST: _____
_____
_____

MEDICATIONS:
LIST: _____
_____
_____

INSURANCE AND PHYSICIAN INFO

COMPANY: _____
POLICY # _____
GROUP # _____
PHONE # _____

PHYSICIAN: _____
PHONE # _____
DENTIST: _____
PHONE # _____

TYPE: ____ HMO ____ PPO ____ POS

** DOES YOUR PHYSICIAN ___ OR INSURANCE CO. ___ NEED TO BE NOTIFIED PRIOR TO EMERGENCY CARE?

HOSPITAL PREFERENCE

IN THE EVENT OF AN EMERGENCY, I AUTHORIZE EMERGENCY CARE PROVIDERS TO TAKE MY SON/DAUGHTER TO THE FOLLOWING HOSPITAL FOR TREATMENT. MARK SPECIFIC HOSPITAL(S) OR "ANY HOSPITAL" IF THE NEAREST FACILITY IS PERMITTED. REMEMBER, YOUR CHILD WILL BE PLAYING IN CONTESTS AWAY FROM BISHOP MCDEVITT HIGH SCHOOL.

____ ANY HOSPITAL ____ HOLY SPIRIT ____ HARRISBURG ____ COMMUNITY GENERAL ____ HERSHEY MEDICAL CENTER

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

INFORMATION RELEASE AUTHORIZATION

BY THIS SIGNATURE, I HEREBY CONSENT TO ALLOW THE PHYSICIAN(S) AND OTHER HEALTH CARE PROVIDERS(S) SELECTED BY MYSELF OR THE SCOOL TO PERFORM A PRE-PARTICIPATION EXAM AND TO PROVIDE TREATMENT FOR ANY INJURY RECEIVED WHILE PARTICIPATING IN ATHLETICS FOR HIS/HER SCHOOL DURING THE SCHOOL YEAR COVERED BY THIS FORM. I FURTHER CONSENT TO ALLOW SAID PHYSICIAN(S) OR HEALTH CARE PROVIDER(S) TO SHARE APPROPRIATE INFORMATION CONCERNING MY CHILD THAT IS RELEVANT TO MY CHILD'S PARTICIPATION WITH COACHES AND OTHER SCHOOL PERSONNEL AS DEEMED NECESSARY.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

PLEASE NOTIFY THE ATHLETIC TRAINER IF ANY OF THIS INFORMATION CHANGES DURING THE SCHOOL YEAR

PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION

INITIAL EVALUATION: Prior to any student participating in Practices, Inter-School Practices, Scrimmages, and/or Contests, at any PIAA member school in any school year, the student is required to (1) complete a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE); and (2) have the appropriate person(s) complete the first six Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, and 5 by the student and parent/guardian; and Section 6 by an Authorized Medical Examiner (AME), those Sections must be turned in to the Principal, or the Principal's designee, of the student's school for retention by the school. The CIPPE may not be authorized earlier than June 1st and shall be effective, regardless of when performed during a school year, until the latter of the next May 31st or the conclusion of the spring sports season.

SUBSEQUENT SPORT(S) IN THE SAME SCHOOL YEAR: Following completion of a CIPPE, the same student seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) in the same school year, must complete Section 7 of this form and must turn in that Section to the Principal, or Principal's designee, of his or her school. The Principal, or the Principal's designee, will then determine whether Section 8 need be completed.

SECTION 1: PERSONAL AND EMERGENCY INFORMATION

PERSONAL INFORMATION

Student's Name _____ Male/Female (circle one)

Date of Student's Birth: ____/____/_____ Age of Student on Last Birthday: ____ Grade for Current School Year: ____

Current Physical Address _____

Current Home Phone # ( )_____ Parent/Guardian Current Cellular Phone # ( )_____

Fall Sport(s): _____ Winter Sport(s): _____ Spring Sport(s): _____

EMERGENCY INFORMATION

Parent's/Guardian's Name_____ Relationship _____

Address _____ Emergency Contact Telephone # ( )_____

Secondary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # ( )_____

Medical Insurance Carrier_____ Policy Number_____

Address _____Telephone # ( ) _____

Family Physician's Name_____, MD or DO (circle one)

Address _____Telephone # ( ) _____

Student's Allergies_____

Student's Health Condition(s) of Which an Emergency Physician or Other Medical Personnel Should be Aware_____

_____

_____

_____

Student's Prescription Medications and conditions of which they are being prescribed _____

_____

SECTION 2: CERTIFICATION OF PARENT/GUARDIAN

The student's parent/guardian must complete all parts of this form.

A. I hereby give my consent for _____ born on _____ who turned _____ on his/her last birthday, a student of _____ School and a resident of the _____ public school district, to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 20____ - 20____ school year in the sport(s) as indicated by my signature(s) following the name of the said sport(s) approved below.

Fall Sports	Signature of Parent or Guardian
Cross Country	
Field Hockey	
Football	
Golf	
Soccer	
Girls' Tennis	
Girls' Volleyball	
Water Polo	
Other	

Winter Sports	Signature of Parent or Guardian
Basketball	
Bowling	
Competitive Spirit Squad	
Girls' Gymnastics	
Rifle	
Swimming and Diving	
Track & Field (Indoor)	
Wrestling	
Other	

Spring Sports	Signature of Parent or Guardian
Baseball	
Boys' Lacrosse	
Girls' Lacrosse	
Softball	
Boys' Tennis	
Track & Field (Outdoor)	
Boys' Volleyball	
Other	

B. Understanding of eligibility rules: I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in Inter-School Practices, Scrimmages, and/or Contests involving PIAA member schools. Such requirements, which are posted on the PIAA Web site at www.piaa.org, include, but are not necessarily limited to age, amateur status, school attendance, health, transfer from one school to another, season and out-of-season rules and regulations, semesters of attendance, seasons of sports participation, and academic performance.

Parent's/Guardian's Signature _____ Date____/____/_____

C. Disclosure of records needed to determine eligibility: To enable PIAA to determine whether the herein named student is eligible to participate in interscholastic athletics involving PIAA member schools, I hereby consent to the release to PIAA of any and all portions of school record files, beginning with the seventh grade, of the herein named student specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, health records, academic work completed, grades received, and attendance data.

Parent's/Guardian's Signature _____ Date____/____/_____

D. Permission to use name, likeness, and athletic information: I consent to PIAA's use of the herein named student's name, likeness, and athletically related information in video broadcasts and re-broadcasts, webcasts and reports of Inter-School Practices, Scrimmages, and/or Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

Parent's/Guardian's Signature _____ Date____/____/_____

E. Permission to administer emergency medical care: I consent for an emergency medical care provider to administer any emergency medical care deemed advisable to the welfare of the herein named student while the student is practicing for or participating in Inter-School Practices, Scrimmages, and/or Contests. Further, this authorization permits, if reasonable efforts to contact me have been unsuccessful, physicians to hospitalize, secure appropriate consultation, to order injections, anesthesia (local, general, or both) or surgery for the herein named student. I hereby agree to pay for physicians' and/or surgeons' fees, hospital charges, and related expenses for such emergency medical care. I further give permission to the school's athletic administration, coaches and medical staff to consult with the Authorized Medical Professional who executes Section 6 regarding a medical condition or injury to the herein named student.

Parent's/Guardian's Signature _____ Date____/____/_____

F. CONFIDENTIALITY: The information on this CIPPE shall be treated as confidential by school personnel. It may be used by the school's athletic administration, coaches and medical staff to determine athletic eligibility, to identify medical conditions and injuries, and to promote safety and injury prevention. In the event of an emergency, the information contained in this CIPPE may be shared with emergency medical personnel. Information about an injury or medical condition will not be shared with the public or media without written consent of the parent(s) or guardian(s).

Parent's/Guardian's Signature _____ Date____/____/_____

SECTION 3: UNDERSTANDING OF RISK OF CONCUSSION AND TRAUMATIC BRAIN INJURY

What is a concussion?
A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body.
- Can change the way a student's brain normally works.
- Can occur during Practices and/or Contests in any sport.
- Can happen even if a student has not lost consciousness.
- Can be serious even if a student has just been "dinged" or "had their bell rung."

All concussions are serious. A concussion can affect a student's ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most students with a concussion get better, but it is important to give the concussed student's brain time to heal.

What are the symptoms of a concussion?
Concussions cannot be seen; however, in a potentially concussed student, ***one or more*** of the symptoms listed below may become apparent and/or that the student "doesn't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

What should students do if they believe that they or someone else may have a concussion?

- **Students feeling any of the symptoms set forth above should immediately tell their Coach and their parents.** Also, if they notice any teammate evidencing such symptoms, they should immediately tell their Coach.
- **The student should be evaluated.** A licensed physician of medicine or osteopathic medicine (MD or DO), sufficiently familiar with current concussion management, should examine the student, determine whether the student has a concussion, and determine when the student is cleared to return to participate in interscholastic athletics.
- **Concussed students should give themselves time to get better.** If a student has sustained a concussion, the student's brain needs time to heal. While a concussed student's brain is still healing, that student is much more likely to have another concussion. Repeat concussions can increase the time it takes for an already concussed student to recover and may cause more damage to that student's brain. Such damage can have long term consequences. It is important that a concussed student rest and not return to play until the student receives permission from an MD or DO, sufficiently familiar with current concussion management, that the student is symptom-free.

How can students prevent a concussion? Every sport is different, but there are steps students can take to protect themselves.

- Use the proper sports equipment, including personal protective equipment. For equipment to properly protect a student, it must be:
  The right equipment for the sport, position, or activity;
  Worn correctly and the correct size and fit; and
  Used every time the student Practices and/or competes.
- Follow the Coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

If a student believes they may have a concussion: Don't hide it. Report it. Take time to recover.

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Student's Signature _____ Date___/___/_____

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Parent's/Guardian's Signature _____ Date___/___/_____

SECTION 4: UNDERSTANDING OF SUDDEN CARDIAC ARREST SYMPTOMS AND WARNING SIGNS

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 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?

There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year.

Are there warning signs?

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

- dizziness
- lightheadedness
- shortness of breath
- difficulty breathing
- racing or fluttering heartbeat (palpitations)
- syncope (fainting)
- fatigue (extreme tiredness)
- weakness
- nausea
- vomiting
- chest pains

These symptoms can be unclear and confusing in athletes. Often, people 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 have SCA die from it.

Act 59 – the Sudden Cardiac Arrest Prevention Act (the Act)

The Act is intended to keep student-athletes safe while practicing or playing. The requirements of the Act are:

Information about SCA symptoms and warning signs.

- Every student-athlete and their parent or guardian 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.
- Schools may *also* hold informational meetings. The meetings can occur before each athletic season. Meetings may include student-athletes, parents, coaches and school officials. Schools may also want to include doctors, nurses, and athletic trainers.

Removal from play/return to play

- Any student-athlete who has signs or symptoms of SCA must be removed from play. The symptoms can happen before, during, or after activity. Play includes all athletic activity.
- Before returning to play, the athlete must be evaluated. Clearance to return to play must be in writing. The evaluation must be performed by a licensed physician, certified registered nurse practitioner, or cardiologist (heart doctor). The licensed physician or certified registered nurse practitioner may consult any other licensed or certified medical professionals.

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

_____ _____ Date____/____/_____

Signature of Student-Athlete Print Student-Athlete's Name

_____ _____ Date____/____/_____

Signature of Parent/Guardian Print Parent/Guardian's Name

Student's Name _____ Age_____ Grade_____

SECTION 5: HEALTH HISTORY

Explain "Yes" answers at the bottom of this form.
Circle questions you don't know the answers to.

		Yes	No
1.	Has a doctor ever denied or restricted your participation in sport(s) for any reason?	☐	☐
2.	Do you have an ongoing medical condition (like asthma or diabetes)?	☐	☐
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5.	Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6.	Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8.	Does your heart race or skip beats during exercise?	☐	☐
9.	Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ Heart murmur ☐ High cholesterol ☐ Heart infection		
10.	Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	☐	☐
11.	Has anyone in your family died for no apparent reason?	☐	☐
12.	Does anyone in your family have a heart problem?	☐	☐
13.	Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?	☐	☐
14.	Does anyone in your family have Marfan syndrome?	☐	☐
15.	Have you ever spent the night in a hospital?	☐	☐
16.	Have you ever had surgery?	☐	☐
17.	Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a Practice or Contest? If yes, circle affected area below:	☐	☐
18.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐
	Head Neck Shoulder Upper arm Elbow Forearm Hand/ Fingers Chest Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/ Toes		
20.	Have you ever had a stress fracture?	☐	☐
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22.	Do you regularly use a brace or assistive device?	☐	☐

		Yes	No
23.	Has a doctor ever told you that you have asthma or allergies?	☐	☐
24.	Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	☐	☐
25.	Is there anyone in your family who has asthma?	☐	☐
26.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
27.	Were you born without or are your missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28.	Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30.	Have you ever had a herpes skin infection?	☐	☐
	CONCUSSION OR TRAUMATIC BRAIN INJURY		
31.	Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	☐	☐
32.	Have you been hit in the head and been confused or lost your memory?	☐	☐
33.	Do you experience dizziness and/or headaches with exercise?	☐	☐
34.	Have you ever had a seizure?	☐	☐
35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37.	When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39.	Have you had any problems with your eyes or vision?	☐	☐
40.	Do you wear glasses or contact lenses?	☐	☐
41.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42.	Are you unhappy with your weight?	☐	☐
43.	Are you trying to gain or lose weight?	☐	☐
44.	Has anyone recommended you change your weight or eating habits?	☐	☐
45.	Do you limit or carefully control what you eat?	☐	☐
46.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐
	FEMALES ONLY		
47.	Have you ever had a menstrual period?	☐	☐
48.	How old were you when you had your first menstrual period?	_____	
49.	How many periods have you had in the last 12 months?	_____	
50.	Are you pregnant?	☐	☐

#'s	Explain "Yes" answers here:

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature _____ Date___/___/____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature _____ Date___/___/____

SECTION 6: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER

Must be completed and signed by the Authorized Medical Examiner (AME) performing the herein named student's comprehensive initial pre-participation physical evaluation (CIPPE) and turned in to the Principal, or the Principal's designee, of the student's school.

Student's Name_____ Age_____ Grade_____

Enrolled in _____ School Sport(s) _____

Height_____ Weight_____ % Body Fat (optional) _____ Brachial Artery BP_____/_____ (_____/_____, _____/_____) RP_____

If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student's primary care physician is recommended.

Age 10-12: BP: >126/82, RP: >104; **Age 13-15:** BP: >136/86, RP >100; **Age 16-25:** BP: >142/92, RP >96.

Vision: R 20/_____ L 20/_____ Corrected: YES NO (circle one) Pupils: Equal_____ Unequal_____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		☐ Heart murmur ☐ Femoral pulses to exclude aortic coarctation ☐ Physical stigmata of Marfan syndrome
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student's parent/guardian in Section 2 of the PIAA Comprehensive Initial Pre-Participation Physical Evaluation form:

☐ **CLEARED** ☐ **CLEARED**, with recommendation(s) for further evaluation or treatment for:_____

☐ **NOT CLEARED** for the following types of sports (please check those that apply):

☐ COLLISION ☐ CONTACT ☐ NON-CONTACT ☐ STRENUOUS ☐ MODERATELY STRENUOUS ☐ NON-STRENUOUS

Due to _____

Recommendation(s)/Referral(s) _____

AME's Name (print/type) _____ License #_____

Address_____ Phone ( )_____

AME's Signature_____MD, DO, PAC, CRNP, or SNP *(circle one)* Certification Date of CIPPE ___/___/___