



PREPARTICIPATION PHYSICAL EVALUATION – Ohio High School Athletic Association – 2020-2021

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____ Grade in School: _____

Date of examination: _____ Sport(s): _____

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

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). _____

Do you have any allergies? If yes, please list all your allergies (i.e., medicines, pollens, food, stinging insects). _____

Patient Health Questionnaire Version 4 (PHQ-4)
Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

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

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

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

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)		
	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		
	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

**PREPARTICIPATION PHYSICAL EVALUATION – Ohio High School Athletic Association – 2020-2021
ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY**

Name: _____ Date of birth: _____

1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or 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 as having 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 whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (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 questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

PREPARTICIPATION PHYSICAL EVALUATION – Ohio High School Athletic Association – 2020-2021

PHYSICAL EXAMINATION FORM

Name: _____ Date of Birth: _____ Grade in School: _____

PHYSICIAN REMINDERS

- Consider additional questions on more-sensitive issues.
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, e-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-enhancing 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 (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
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, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart ^a • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

^a Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, DC, NP, or PA

PREPARTICIPATION PHYSICAL EVALUATION – OHIO HIGH SCHOOL ATHLETIC ASSOCIATION – 2020-21
MEDICAL ELIGIBILITY FORM

Name: _____ Date of Birth: _____ Grade in School: _____

- Medically eligible for all sports without restriction
- Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

- Medically eligible for certain sports

- Not medically eligible pending further evaluation
- Not medically eligible for any sports

Recommendations: _____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date of Exam: _____

Address: _____ Phone: _____

Signature of health care professional: _____ MD, DO, DC, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

Medications: _____

Other information: _____

Emergency contacts: _____

**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 2020-2021

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 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

PREPARTICIPATION PHYSICAL EVALUATION 2020-2021
2020-2021 Ohio High School Athletic Association Eligibility and Authorization Statement

This document is to be signed by the participant from an OHSAA member school and by the participant's parent.


 I have read, understand and acknowledge receipt of the **OHSAA Student Eligibility Guide and Checklist** <https://www.ohsaa.org/Portals/0/Eligibility/OtherEligibilityDocs/EligibilityGuideHS.pdf> which contains a summary of the eligibility rules of the Ohio High School Athletic Association. I understand that a copy of the *OHSAA Handbook* is on file with the principal and athletic administrator and that I may review it, in its entirety, if I so choose. All OHSAA bylaws and regulations from the *Handbook* are also posted on the OHSAA website at ohsaa.org.


 I understand that an OHSAA member school must **adhere to all rules and regulations** that pertain to the interscholastic athletics programs that the school sponsors, but that local rules may be more stringent than OHSAA rules.

 I understand that participation in interscholastic athletics is a **privilege not a right**.


Student Code of Responsibility

 As a student athlete, I **understand and accept** the following responsibilities:


 I will **respect the rights and beliefs** of others and will treat others with courtesy and consideration.


 I will be **fully responsible** for my own actions and the consequences of my actions.


 I will **respect the property** of others.


 I will **respect and obey the rules** of my school and laws of my community, state and country.


 I will **show respect to those who are responsible for enforcing the rules** of my school and the laws of my community, state and country.


 I understand that a student whose character or conduct violates the school's Athletic Code or School Code of Responsibility is not in good standing and is ineligible for a period as determined by the principal.


 **Informed Consent** – By its nature, participation in interscholastic athletics includes risk of injury and transmission of infectious disease such as HIV and Hepatitis B. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants have a responsibility to help reduce that risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, GUARDIANS OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN AN OHSAA-SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN'S SIGNATURE.**


 I understand that in the case of **injury or illness requiring treatment by medical personnel and transportation to a health care facility**, that a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be treated and transported via ambulance to the nearest hospital.

 I **consent to medical treatment** for the student following an injury or illness suffered during practice and/or a contest.

 To enable the OHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics in an OHSAA member school, I **consent to the release to the OHSAA any and all portions of school record files**, beginning with 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), enrollment documents, financial and scholarship records, residence address of the student, academic work completed, grades received and attendance data.

 I **consent to the OHSAA's use of the herein named student's name**, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.

 I **understand that if I drop a class**, take course work through College Credit Plus, Credit Flexibility or other educational options, this action could affect compliance with OHSAA academic standards and my eligibility. I **accept full responsibility** for compliance with Bylaw 4-4, Scholarship, and the passing five credit standard expressed therein.

 I **understand all concussions are potentially serious** and may result in complications including prolonged brain damage and death if not recognized and managed properly. Further I understand that if my student is removed from a practice or competition due to a suspected concussion, he or she will be unable to return to participation that day. After that day written authorization from a physician (M.D. or D.O.) or another health care provider working under the supervision of a physician will be required in order for the student to return to participation.

 I **have read and signed** the Ohio Department of Health's **Concussion Information Sheet** and have retained a copy for myself.

 I **have read and signed** the Ohio Department of Health's **Sudden Cardia Arrest Information Sheet** and have retained a copy for myself.

 **By signing this we acknowledge that we have read the above information and that we consent to the herein named student's participation.**

***Must Be Signed Before Physical Examination**

Student's Signature

Birth date

Grade in School

Date

Parent's or Guardian's Signature

Date

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 healthcare 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.



<http://www.healthy.ohio.gov/vipp/child/returntoplay/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 Learn (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.
5. For more information, please refer to Return to Learn on [the ODH website](#).

Resources

ODH Violence and Injury Prevention Program
<http://www.healthy.ohio.gov/vipp/child/returntoplay/>

Centers for Disease Control and Prevention
<http://www.cdc.gov/headsup/basics/index.html>

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. Ohio law prohibits your child from returning to a game or practice on the same day he/she was removed.
4. Be sure that the athletic trainer, coach and physical education teacher are aware of your child's injury and symptoms.
5. Your athlete should complete a step-by-step exercise -based progression, under the direction of a qualified healthcare professional.
6. 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 Concussion Information Sheet

For Interscholastic Athletics

I have read the Ohio Department of Health's Concussion Information Sheet and understand that I have a responsibility to report my/my child's symptoms to coaches, administrators and healthcare provider.

I also understand that I/my child must have no symptoms before return to play can occur.

Athlete

Date

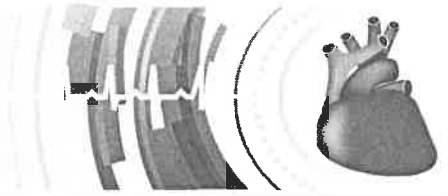
Athlete *Please Print Name*

Parent/Guardian

Date



Sudden Cardiac Arrest and Lindsay's Law Parent/Athlete Signature Form



What is Lindsay's Law? Lindsay's Law is about Sudden Cardiac Arrest (SCA) in youth athletes. It covers all athletes 19 years or younger who practice for or compete in athletic activities. Activities may be organized by a school or youth sports organization.

Which youth athletic activities are included in Lindsay's law?

- Athletics at all schools in Ohio (public and non-public)
- Any athletic contest or competition sponsored by or associated with a school
- All interscholastic athletics, including all practices, interschool practices and scrimmages
- All youth sports organizations
- All cheerleading and club sports, including noncompetitive cheerleading

What is SCA? SCA is when the heart stops beating suddenly and unexpectedly. This cuts off blood flow to the brain and other vital organs. People with SCA will die if not treated immediately. SCA can be caused by 1) a structural issue with the heart, OR 2) an heart electrical problem which controls the heartbeat, OR 3) a situation such as a person who is hit in the chest or a gets a heart infection.

What is a warning sign for SCA? If a family member died suddenly before age 50, or a family member has cardiomyopathy, long QT syndrome, Marfan syndrome or other rhythm problems of the heart.

What symptoms are a warning sign of SCA? A young athlete may have these things with exercise:

- Chest pain/discomfort
- Unexplained fainting/near fainting or dizziness
- Unexplained tiredness, shortness of breath or difficulty breathing
- Unusually fast or racing heart beats

What happens if an athlete experiences syncope or fainting before, during or after a practice, scrimmage, or competitive play? The coach MUST remove the youth athlete from activity immediately. The youth athlete MUST be seen and cleared by a health care provider before returning to activity. This written clearance must be shared with a school or sports official.

What happens if an athlete experiences any other warning signs of SCA? The youth athlete should be seen by a health care professional.

Who can evaluate and clear youth athletes? A physician (MD or DO), a certified nurse practitioner, a clinical nurse specialist, certified nurse midwife. For school athletes, a physician's assistant or licensed athletic trainer may also clear a student. That person may refer the youth to another health care provider for further evaluation.

What is needed for the youth athlete to return to the activity? There must be clearance from the health care provider in writing. This must be given to the coach and school or sports official before return to activity.

All youth athletes and their parents/guardians must review information about Sudden Cardiac Arrest, then sign and return this form.

Parent/Guardian Signature

Student Signature

Parent/Guardian Name (Print)

Student Name (Print)

Date

Date

ATHLETIC CODE OF CONDUCT AND EXPECTATIONS
INFORMED CONSENT AGREEMENT

Student's Name _____ Grade _____
(Please Print)

AS A STUDENT:

I understand and agree that participation in athletic or extra-curricular activities and parking on District property is a privilege that may be withdrawn for violations of the Student Code of Conduct and the Athletic Handbook.

I have read and thoroughly understand the consequences that I will face if I do not honor my commitment to the Athletic Handbook.

I understand and realize that there is risk of injury in participating in athletic activities.

I understand that when I participate in any athletic program, extra-curricular activity, and/or receive a parking permit, I will be subjected random urine drug testing; and if I refuse, I will not be allowed to practice or participate in activities outlined in this policy or park on District property. I have read the Consent to Perform Urinalysis for Drug Testing below and agree to its terms.

I understand this is binding while I am a student within the District.

Student Signature Date

AS A PARENT/GUARDIAN/CUSTODIAN:

I have read the Athletic Handbook and understand the responsibilities of my son/daughter/ward as a participant in athletic, extra-curricular activities, and/or parking privileges in the District.

I understand and realize that there is an assumed risk of injury involved for my son/daughter/ward as a participant in athletic activities.

I understand that when my son/daughter/ward, when participate in athletics, extra-curricular activities, and/or receiving a parking permit, may be subjected to initial and random urine drug testing, and if they refuse, will not be allowed to practice or participate in activities described in this policy or park on District property. I have read the Consent to Perform Urinalysis for Drug Testing below and agree to its terms.

I understand this is binding while my son/daughter/ward is a student within the District.

Parent/Guardian/Custodian Signature

Date

Parent/Guardian/Custodian Name (Print)

Home Phone

Work Phone

***There is a \$10.00 charge to be enrolled in the drug testing program. The \$10.00 must be paid prior to the student being eligible for extracurricular activities.**

***All students must pay the \$10.00. Fees are not waived for Extra Curricular Programs.**

***There is no initial testing when you enroll in the drug testing program. All testing will be random throughout the school year.**

Consent to Perform Urinalysis for Drug Testing

We hereby consent to allow the student to undergo urinalysis testing for the presence of illicit drugs or banned substances in accordance with the Policy and Procedure for Random Urine Drug Testing of Students as approved by the Board.

We understand that the collection process will be overseen by a qualified vendor.

We understand that any urine samples will be sent only to a certified medical laboratory for actual testing, and that the samples will be coded to provide confidentiality.

We hereby give our consent to the medical vendor selected by the Board, their laboratory, doctors, employees, or agents, together with any clinic, hospital, or laboratory designated by the selected medical vendor to perform urinalysis testing for the detection of illicit drugs or banned substances.

We further give permission to the medical vendor selected by the Board, its doctors, employees, or agents, to release all results of these test to the Medical Review Officer (MRO) working for the medical vendor. We understand these results will be forwarded to the building principal, athletic director, assistant to the athletic director, and Superintendent and will also be made available to us.

We understand that consent pursuant to this Informed Consent Agreement will be effective for all activities in which this student might participate during the current school year.

We hereby release the Board, Great Lakes Biomedical, SPORT SAFE Testing Service, Inc., and its employees from any legal responsibility or liability for the release of such information and records.

12/06

Revised 5/19/09

Revised 8/17/11

Revised 5/4/12

EMERGENCY MEDICAL AUTHORIZATION FORM

School District	School Building	Home Room Teacher	Grade
Student's Full Name _____			
Last	First	Middle	
Student's Address _____			
Street/Rd	P.O Box/Appt #	City	Zip Code
Student's Birth date _____		Home Phone (____) _____	
Mother's Full Name _____		Work Daytime Phone (____) _____	
Father's Full Name _____		Work Daytime Phone (____) _____	
Guardian's Full Name _____		Work Daytime Phone (____) _____	
Name of Relative/Childcare Provider: _____		Work Daytime Phone (____) _____	
Relative/Childcare Provider Address _____		Relationship : _____	

Emergency Contact Information

In case of an emergency involving your child and you cannot be reached, list alternate contacts

PRIMARY Alternate Emergency Contact : _____	Relationship to child	Tel: (____) _____
Address _____		
Street/Rd	P.O Box/Appt #	City
		Zip Code

SECOND Alternate Emergency Contact : _____	Relationship to child	Tel: (____) _____
Address _____		
Street/Rd	P.O Box/Appt #	City
		Zip Code

Medical Information

List facts concerning the child's medical history to which a physician should be alerted: _____

List medication allergies and/or other allergies _____

List any physical impairments: _____

List current medications being taken: _____

PART 1 OR PART 2 MUST BE COMPLETED

PART 1: PARENT/GUARDIAN SIGNATURE AND MEDICAL RELEASE

All information is complete and correct. I am the child's custodial parent or legal guardian or I am the student age 18 or older. I grant permission to my child's school, in an emergency when I (or my physician) cannot be contacted, to take my child to the emergency room of the nearest hospital, and the hospital and its emergency staff have my authorization to provide treatment which a physician deems necessary for the well being of my child.

Signature(s) of Parent/Guardian	Parent/Guardian Name(s) PRINT	Date Signed
---------------------------------	-------------------------------	-------------

PART 2: REFUSAL TO CONSENT TO MEDICAL TREATMENT

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 the following action:

Student's Name:		
Signature(s) of Parent/Guardian	Parent/Guardian Name(s) PRINT	Date Signed

Southeastern Local School District

**Permission for Administration
Of
Non-Prescription (OTC) Medications**

For students in grades 7-12: Staff designated by the building principal including the Athletic Trainer will dispense only those non-prescription medication for which written and/or verbal permission from a parent/guardian has been received.

I give permission for the following non-prescription medications to be given to my child in the dose noted below (please check appropriate dose):

Directions: Adults and children 12 years and older- Take 2 tablets every 4-6 hours as needed. Directions may differ between brand names. Students will never be given more than the recommended dosage in the time frame given in directions.

Acetaminophen (Tylenol or Generic)

1 Tablet (250mg) _____ or 2 Tablets (500mg) _____

Ibuprofen (Advil, Motrin, or Generic)

1 Tablet (200mg) _____ or 2 Tablets (400mg) _____

Cough Drops

As directed on package _____

Tums (or generic Antacid)

1 Chewable Tablet _____ or 2 Chewable Tablets _____

***Student's Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

I DO NOT give consent for any non-prescription medications to be administered to my child.

Parent/Guardian Signature: _____ Date: _____