PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

Boiling Springs High School

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

Date of Exam _____

Name _____ Date of birth _____

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

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

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ 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, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

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

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

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

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

Preparticipation Physical Evaluation
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, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight	☐ Male ☐ Female	
BP / (/) Pulse	Vision R 20/ L 20/	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[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

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

☐ Cleared for all sports without restriction

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

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

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

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

Name (please print) _____

As a parent or legal guardian of the above named student-athlete. I give permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

Signature of Athlete _____ _____
Date

Signature of Parent/Guardian _____ _____
Date

Spartanburg School District Two (SSD2)
Athlete/Parent Concussion Statement

PARENTS and ATHLETE please **INITIAL** in each box

Parent	Athlete	
☐	☐	I understand that it is my responsibility to report all injuries and illnesses to my athletic trainer.
☐	☐	I have read and understand the CDC Concussion Fact sheet for parents.
☐	☐	I have read and understand the CDC Concussion Fact sheet for athletes.

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

☐	☐	A concussion is a brain injury that I am responsible for reporting to my athletic trainer, physician, or coach.
☐	☐	A concussion can affect everyday activities, athletic performance, balance, sleep, reaction time, and classroom performance.
☐	☐	If I suspect a teammate has a concussion, I am responsible for reporting the injury to my athletic trainer.
☐	☐	I will not return to activity on the same day if I have received a blow to the head or body that results in concussion related symptoms.
☐	☐	Following a concussion, the brain needs time to heal. You are much more likely to have another concussion if you return to play prior to your symptoms resolving.
☐	☐	In rare cases, repeat concussions can cause permanent brain damage or even death.
☐	☐	I understand that physician clearance, and completion of Return to Play Protocol, must be completed before an athlete returns to full participation.

Student Athlete Signature	Parent Signature	Date
Printed Name of Student	Printed Name of Parent	

STEADMAN HAWKINS SPORTS MEDICINE SERVICES
CONSENT AND AUTHORIZATION

I, _____, parent/legal guardian of _____, a student/participant at _____ (the "School/Event") authorize Greenville Health System ("GHS") staff to provide my child any healthcare services offered by Steadman Hawkins Sports Medicine ("SHSM") and to make appropriate referrals for my child to receive any additional health services that my child's condition may indicate. To protect and improve the health of athletes, GHS will provide athletic trainers to provide on-site treatment and consultation to student/participants. These services will be overseen by a physician serving as Medical Director for SHSM.

In addition, in the event my child needs urgent or emergency treatment off-site, I authorize staff of SHSM to arrange for such care, including appropriate transportation. I understand that SHSM staff will contact me as soon as possible in the event my child has an urgent or emergency condition. I agree to complete all health history, family history, and other informational requests necessary for my child's participation in the SHSM program. I understand that I may contact the Athletic Trainer assigned to the School or the Medical Director for SHSM to discuss my child's care or to discuss any questions I may have about the program. I consent to the release by GHS/SHSM staff of information about my child's medical condition obtained through SHSM Services to physicians, coaches, and other employees or agents of GHS or to whom I am referred. I also consent to the release of information about my child's medical condition to necessary staff at the school, should accommodations be needed to aid in my child's education.

I understand that I will not be charged for services rendered on-site by the medical staff, but that I or my child's insurance carrier may be charged for services rendered by other healthcare providers. I consent for information in my child's medical record to be released for the purpose of filing health insurance claims with third-party payers. I hereby authorize GHS to submit claims for services rendered to my child and assign to GHS my rights to any reimbursement for such services.

In consideration for the services provided to my child by SHSM, I hereby release Greenville Health System, its trustees, officers, employees, and agents from and against any claim, liability, and cause of action or other expense arising out of the services provided by GHS Sports Medicine Services.

I acknowledge by signing below that I have received a copy of the GHS Notice of Privacy Practices.

I have read and understand the above information and consent to my child's participation in GHS Sports Medicine Services.

_____ _____
Name of Parent/Guardian (please print) Signature of Parent/Guardian

_____ _____
Name of Student (First, Middle, Last) Witness/Date

STEADMAN HAWKINS SPORTS MEDICINE

Athlete's Name_____ DOB_____ SSN_____ Grade ____
(First / Middle / Last)

School_____ Sport(s) _____

Guardian(s) _____ Phone #'s (h) _____(c) _____
Relationship(s) _____

Address _____
Street City State Zip

Guardian(s) Email _____Student Athlete's Email_____
(For SHSM Emails of Athletic Training/Conditioning Topics)

Emergency contact _____ Phone #'s (h) _____ (c) _____
(Guardians will be contacted first in case of emergency, please list individual other than listed above)

Ins. Carrier _____ HMO/PPO Group/Policy# _____
(circle one)

Insurance Preferred Network/Provider: **yes/no** (circle one) Whom _____

Does your child have any of the following? (List details as appropriate)		Yes	No
Asthma	_____	□	□
Inhaler	_____	□	□
Heart condition	_____	□	□
Vision loss	_____	□	□
Epilepsy	_____	□	□
Diabetes	_____	□	□
Kidney condition	_____	□	□
Hearing loss	_____	□	□
Allergies	_____	□	□
Medication Allergy	_____	□	□
Severe headaches	_____	□	□

Previous injuries/surgeries (month/year) _____
_____

Is your child on any medication that is taken on a regular basis? (List) _____
_____

Does your family have a primary care physician? (Name & phone #)_____

Does your family have an orthopaedic doctor? (Name & phone #) _____

My child may take any over-the-counter medication such as Tylenol®/Advil® YES NO

_____ _____
Parent/Guardian Signature Date

May 6, 2011

GREENVILLE HEALTH SYSTEM NOTICE OF PRIVACY PRACTICES

This notice describes how your medical information may be used and released and how you can get this information. Please read it carefully.

Greenville Health System (GHS) makes every effort to keep your health information private. Each time you visit GHS, a record is made. This health or medical record often includes your symptoms, exams and tests, diagnoses, treatment, and care plan. We need this record to give you high-quality care and to meet legal requirements.

This Notice applies to all health records produced at GHS, including those received from other providers. It outlines how we may use and give out information about you for treatment, payment, or healthcare operations, and other purposes granted or required by law. It also describes your rights to get and control your record, and legal requirements we have on its use and release.

This Notice applies to all GHS sites including offices of physicians employed by GHS and to all physicians and other healthcare providers who provide you with healthcare services at any GHS site. It does not apply to care you receive from physicians or other healthcare providers at their private offices (unless the physician or other healthcare provider is employed by GHS) or at any non-GHS site.

The law requires GHS to do the following:

- Keep your health record private
- Describe our legal duties and privacy obligations related to your health information
- Follow the current Notice of Privacy Practices

We reserve the right to change the practices and terms of this Notice and the changes will be effective for the information we already have about you as well as any information we receive in the future. The Notice will list the start date in the top right-hand corner of the first page.

Each time you register at GHS, you may request a copy of the notice. We will post it in our facilities and on our Web site (www.ghs.org). You may also call our Privacy Office at 864-797-7755 for a copy.

ROUTINE USES AND DISCLOSURES OF YOUR HEALTH RECORD

The following sections describe how we use and release medical information. Each section explains what we mean and gives a few examples. (Note: These examples are not all-inclusive.)

- **Treatment**. We use medical information about you to provide, coordinate, and manage your treatment or services. We may give this information to doctors, nurses, technicians, students of affiliated healthcare programs, volunteers, or other staff who care for you. Various units may share information about you to coordinate your needs, such as lab work or drugs.

  We may give details about you to people who are involved in your care, such as a specialist, spouse, or friend. GHS medical personnel and employees, using their best judgment, may release to a relative, close friend, or other person information about your health related to that person's involvement in your care.

  Here is how your health record might be used for treatment reasons:
  - We may send your record to specialists your doctors here may want to consult.
  - Your record may be sent to a doctor to whom you have been referred.
  - You may plan for a friend to pick you up after a procedure. A GHS representative may believe it is in your best interest to tell your friend what drug you must take that night and what will speed your recovery at home.
  - We may use and release your health record to provide material on treatment options.

- **Payment**. We use and release health information so that treatment and services you receive may be billed to and payment collected from you, an insurance company, or a third party.

  Here is how your health record might be used for payment purposes.
  - We may call your health plan for pre-approval of a service.
  - We may give your health plan details about your surgery, so it will pay us or reimburse you.
  - If someone else is responsible for your payment, we will contact that person.

- **Healthcare Operations**. We may use and release your record to support our business functions (for example, administrative, financial, and legal activities). These uses and disclosures are needed to run the hospital, support treatment and payment, and help patients receive high-quality care. Activities may include measuring quality, reviewing employee performance, and training students.

  Here is how your health record might be used for business operations.
  - We may call you to confirm your appointment.
  - We may ask you to list your name and your doctor's name when you arrive for a visit. We may also call you by name in a waiting area.
  - We may use health information to review our treatment and services.
  - We may give information to doctors, nurses, technicians, students, and other staff for review and learning purposes.
  - We may combine our records with those from other hospitals or practices to compare how we are doing and where we can improve.

- **Facility Directory**. Unless you object in writing, we include certain facts about you in our directory while you are a patient at a GHS hospital, clinic, or doctor's office. These facts may include your name, location, general condition (e.g., fair, stable), and religious affiliation. They may also be shared with those who ask for you by name (except for religious affiliation). Your affiliation may be given to clergy members, even if they don't ask for you by name. This is so family members, friends, and clergy can visit you or know how you are doing.

- **People Involved in Your Care or Payment for Your Care**. Unless you object, GHS health experts may tell a family member, friend, or other person you identify, or that we have a reasonable basis to believe is involved in your medical care, details about you that relate to that person's involvement in your care. If you cannot physically or mentally agree or object to a disclosure, we may supply information as needed. We may also give information to someone who pays for your care. Finally, we may share facts with someone helping in a disaster relief effort so that family can know of your condition, status, and location.

- **Business Associates**. Business associates of GHS provide some services related to treatment, payment, and business operations. Examples include medical supplies, transcription, medical record storage, and some aspects of billing. We have a written contract that requires associates to protect your record in the course of performing their job.

SPECIAL USES AND DISCLOSURES OF YOUR HEALTH RECORD

- **Emergencies.** We may use or release your health information during emergencies.

- **Language Barriers.** We may use or release your record if we try to get your consent but cannot because of major communication barriers and the doctor or staff decides that you intend to consent to use or release such information.

- **Research**. We may share information about you with researchers starting a project to help them find patients with specific needs (the information will not

leave Greenville Health System). GHS may release your record for research approved by the Greenville Hospital System's Institutional Review Committee (IRC). The IRC reviews proposals and protocols to ensure privacy.

- **Fundraising Events**. We may use your name, address, and dates that you received treatment for Greenville Health System-supported fundraising events. Any fundraising material sent to you will include information telling you what to do to keep from receiving any future communications.

- **Workers' Compensation**. We may release information about you to comply with workers' compensation laws or similar programs.

- **Legal Proceedings**. We may release health information about you in response to a court or administrative order, or in response to a subpoena, discovery request, or other lawful process.

- **Legal Requirements**. We will give out medical information about you when required to do so by federal, state, or local law.

- **Serious Threat to Health or Safety**. We may use and release information about you to prevent a serious threat to your health and safety or the health and safety of others.

- **Health Oversight Activities**. We may supply information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure. These activities help the government oversee healthcare systems, benefit programs, and civil rights laws.

- **Public Health Risks**. We may release information about you to local, state, or federal public health agencies (such as the Food and Drug Administration and the Department of Health and Environmental Control) for reasons such as:
  - To prevent or control disease, injury, or disability
  - To report adverse events, product defects or problems, or drug reactions
  - To notify a person who may have been exposed to a disease or may be at risk for getting or spreading one
  - To alert a government agent if we believe a patient is the victim of abuse, neglect, or domestic violence

- **Coroners, Funeral Directors, and Organ Donors**. We may release information to coroners or medical examiners to identify a deceased person, find cause of death, or carry out duties as required by law. We may also give information to funeral directors to meet their duties and may share such information in the reasonable anticipation of death. We may supply your health record to organ donor groups as approved by you or consistent with the law.

- **Military, Veterans, and National Security**. If you are a member of the armed forces, we may release information about you as required by military authorities. We may also share information about foreign military personnel to the appropriate foreign military authority. We may give information about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Law Enforcement**. We may release your health information to a law enforcement official to identify or locate a suspect, fugitive, witness, or missing person, to provide information about the victim of a crime if, under certain cases, we cannot get the person's agreement or as required by law, or in an emergency to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

- **Inmates**. If you are an inmate of a correctional institution or in custody of a law enforcement official, we may release medical information about you to that facility or person.

YOUR HEALTH INFORMATION RIGHTS

- **Review and Copy**. You have the right to review and request a copy of your health record (this often includes medical and billing records but, under federal law, excludes psychotherapy notes). To do so, write to Medical Information, 701 Grove Road, Greenville SC 29605. There may be a fee for copying, mailing, and related supplies.

  We may deny your request to inspect and copy in certain cases. Then you may request a review. Another licensed healthcare professional chosen by GHS will examine your request. The reviewer will not be the person who denied your request. GHS will comply with the outcome of the review.

- **Amend**. If you believe that information we have about you is incorrect or incomplete, you may ask us to modify or add the information. You have the right to request a change or addition for as long as the record is kept by GHS. Request your change in writing to Medical Information, 701 Grove Road, Greenville SC 29605. You must give a reason that supports your request.

  We may deny your request if it is not in writing or does not include a reason to support the request. We may also deny a request to modify a medical record if the current information is accurate and complete, if it is not part of the medical information kept by or for GHS, if it is not part of what you would be allowed to view and copy, or if it was not created by us. If we deny this request, you have the right to file a statement of disagreement. We may then prepare a rebuttal. We will give you a copy of the rebuttal.

- **Accounting of Disclosures.** You have the right to request an "accounting of disclosures" (a list of disclosures made about you for reasons other than treatment, payment, GHS operations, or national security).

  Request this list by writing to Medical Information, 701 Grove Road, Greenville SC 29605. Your request must state a period of time, which may not be longer than six years and may not include dates before April 14, 2003.

  The first list you request within a 12-month period will be free. Additional lists may involve a charge. We will notify you of the cost, and you may cancel or adjust your request before any fees are incurred.

- **Request Restrictions**. You have the right to request that we limit information we use or give out about you for treatment, payment, or healthcare operations. You also have the right to request a limit on what we release to someone involved in your care or payment for your care, such as a family member. For example, you could ask that we not use or give out information about a surgery that you had to your family.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the material is needed for emergency treatment. To request restrictions, submit a Restriction of Information Agreement Form to GHS's registration personnel. State (1) what you want to limit; (2) if you want to limit use, release, or both; and (3) to whom the limits should apply, for example, disclosures to your family.

- **Request Confidential Communications**. You have the right to request that we interact with you about medical matters in a certain way or place. For example, you can ask that we contact you only by mail or only at work.

  To request confidential communications, submit a Restriction of Information Agreement Form to GHS's registration personnel. We will try to meet all reasonable requests. You must note how or where you wish to be contacted.

COMPLAINTS

If you believe your privacy has been violated, you may file a complaint with Greenville Health System or with the Secretary of the Department of Health and Human Services. To file a complaint , call our Privacy Office at 864-797-7755 or the GHS Service Excellence Department at 864-455-7975. You may also file an anonymous complaint through our Corporate Compliance Hotline at 1-888-243-3611 (1-800-297-8592 en espanol). To ensure proper follow-up, complaints must also be submitted in writing.

OTHER USES

Other uses and disclosures of medical information not covered by this notice or relevant laws will be made only with your written consent. If you allow us to use or release health information about you, you may cancel that consent, in writing, at any time. If you revoke it, we will no longer use or release information for the reasons covered by your written consent. **Note:** We cannot take back disclosures without your consent.

HEADS UP CONCUSSION IN HIGH SCHOOL SPORTS

A FACT SHEET FOR **ATHLETES**

Concussion facts:

- A concussion is a brain injury that affects how your brain works.
- A concussion is caused by a bump, blow, or jolt to the head or body.
- A concussion can happen even if you haven't been knocked out.
- If you think you have a concussion, you should not return to play on the day of the injury and not until a health care professional says you are OK to return to play.

What are the symptoms of a concussion?

Concussion symptoms differ with each person and with each injury, and they may not be noticeable for hours or days. Common symptoms include:

- Headache
- Confusion
- Difficulty remembering or paying attention
- Balance problems or dizziness
- Feeling sluggish, hazy, foggy, or groggy
- Feeling irritable, more emotional, or "down"
- Nausea or vomiting
- Bothered by light or noise
- Double or blurry vision
- Slowed reaction time
- Sleep problems
- Loss of consciousness

During recovery, exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse.

What should I do if I think I have a concussion?

DON'T HIDE IT. REPORT IT. Ignoring your symptoms and trying to "tough it out" often makes symptoms worse. Tell your coach, parent, and athletic trainer if you think you or one of your teammates may have a concussion. Don't let anyone pressure you into continuing to practice or play with a concussion.

GET CHECKED OUT. Only a health care professional can tell if you have a concussion and when it's OK to return to play. Sports have injury timeouts and player substitutions so that you can get checked out and the team can perform at its best. The sooner you get checked out, the sooner you may be able to safely return to play.

TAKE CARE OF YOUR BRAIN. A concussion can affect your ability to do schoolwork and other activities. Most athletes with a concussion get better and return to sports, but it is important to rest and give your brain time to heal. A repeat concussion that occurs while your brain is still healing can cause long-term problems that may change your life forever.

How can I help prevent a concussion?

Every sport is different, but there are steps you can take to protect yourself.

- Follow your coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

If you think you have a concussion:
Don't hide it. Report it. Take time to recover.

It's better to miss one game than the whole season.

For more information, visit **www.cdc.gov/Concussion**.

April 2013

HEADS UP CONCUSSION IN HIGH SCHOOL SPORTS

A FACT SHEET FOR **PARENTS**

What is a concussion?

A concussion is a type of traumatic brain injury. Concussions are caused by a bump or blow to the head. 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. If your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

What are the signs and symptoms of a concussion?

If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs of a concussion:

SYMPTOMS REPORTED BY ATHLETE	SIGNS OBSERVED BY PARENTS/GUARDIANS
• Headache or "pressure" in head • Nausea or vomiting • Balance problems or dizziness • Double or blurry vision • Sensitivity to light • Sensitivity to noise • Feeling sluggish, hazy, foggy, or groggy • Concentration or memory problems • Confusion • Just "not feeling right" or "feeling down"	• Appears dazed or stunned • Is confused about assignment or position • Forgets an instruction • Is unsure of game, score, or opponent • Moves clumsily • Answers questions slowly • Loses consciousness (even briefly) • Shows mood, behavior, or personality changes

How can you help your child prevent a concussion or other serious brain injury?

- Ensure that they follow their coach's rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.
- Make sure they wear the right protective equipment for their activity. Protective equipment should fit properly and be well maintained.
- Wearing a helmet is a must to reduce the risk of a serious brain injury or skull fracture.
  - However, helmets are not designed to prevent concussions. There is no "concussion-proof" helmet. So, even with a helmet, it is important for kids and teens to avoid hits to the head.

What should you do if you think your child has a concussion?

SEEK MEDICAL ATTENTION RIGHT AWAY. A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to regular activities, including sports.

KEEP YOUR CHILD OUT OF PLAY. Concussions take time to heal. Don't let your child return to play the day of the injury and until a health care professional says it's OK. Children who return to play too soon—while the brain is still healing—risk a greater chance of having a repeat concussion. Repeat or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.

TELL YOUR CHILD'S COACH ABOUT ANY PREVIOUS CONCUSSION. Coaches should know if your child had a previous concussion. Your child's coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

If you think your teen has a concussion:
Don't assess it yourself. Take him/her out of play. Seek the advice of a health care professional.

It's better to miss one game than the whole season.

For more information, visit **www.cdc.gov/Concussion**.

April 2013

BSHS Athletic Pre-Participation Paperwork Checklist

- ✓ Completed Pre-Participation History Form
- ✓ Completed Pre-Participation Physical Exam Form
- ✓ Completed Parent's Permission & Assumption of Risk
- ✓ Completed Concussion Education & Acknowledgement Statement
- ✓ Completed GHS Consent for Medical Treatment Forms
- ✓ Official Birth Certificate

*****All forms should be fully completed using a black/blue ink pen.**

Please do not use pencils or permanent markers.***

*****Forms may be printed front and back in the order provided.*****