ATHLETE'S PERMISSION TO PARTICIPATE IN ATHLETICS AT OSD

Students in grades 7-12 may participate in athletic programs at the Ohio School for the Deaf (OSD) under the conditions and procedures established by the Ohio High School Athletic Association (OHSAA) and OSD. The rules involve age, residency, registration, medical examination, academic standards, sportsmanship and other requirements. Other criteria for participation are established by OSD is aimed at promoting academic learning while maintaining athletic programs that are safe, operated efficiently and properly managed. Students in grades 7-12 may participate in competition with other high school teams, in the interest of safety (middle school students may practice and participate). No student who has not yet achieved grade 6 status may participate in a school sponsored sport under Ohio law.

My son/daughter,	, may participate in the
following varsity teams at OSD (please check):	
FEMALE ATHLETICS	MALE ATHLETICS
Volleyball (Fall)	Soccer (Fall)
Basketball (Winter)	Basketball (Winter)
Track and Field (Spring)	Track and Field (Spring)
I understand that he/she will not participate unless a phys	sician has examined my son/daughter
to determine physical eligibility. I understand I am assumi	ng responsibility for any medical costs
incurred should my son/daughter require medical care as	s a result of an injury. I release OSD
and its agents (coaches, athletic managers and athletic	director) from liability should such an
injury occur. Participation in athletic programs will only	be granted after receiving a complete
packet.	
My son/daughter has my permission to travel with the He/she may need a small amount of money if traveling to a understand that all coaches, athletic managers and chape bus, at the competition event, and in the dormitory at a son/daughter will be expected to follow the rules for sp practices, on the bus and at away events. The athletic direction before any travels are to be made that required parents/g to travel out of state on weekends. All OSD school rules s	away events for meals or recreation. I erones will supervise the team on the other schools. I understand that my ortsmanship and general behavior at ector will send travel permission forms juardians to sign before he/she is able
I agree that my son/daughter has a primary responsibilit temporarily excluded from participation should he/sh homework/classwork assignments. Suspension or dismatural consequence for unacceptable behavior. He/she (GPA) of 2.0 or better to maintain eligibility to participate.	ne earn failing grades or neglect nissal from the athletic program is a
Parent/Guardian's Signature	Date



Ohio High School Athletic Association



PREPARTICIPATION PHYSICAL EVALUATION 2018-2019 HISTORY FORM – Please be advised that this paper form is no longer the OHSAA standard.

Page 1 of 6

ne _					Date of birth		
					Sport(s)		
dress	·						
ergei	ncy Contact:		·		Relationship	_	
one (l	H)	(W)	(Cell) _		(Email)		
	licines and Allergies: Please ently taking	ist the prescription and over-the-	-counter medicine	es and sup	oplements (herbal and nutritional-including energy drinks/ protein supplements) that you are	0	_
		s No If yes, please identify					•
	Medicines	Pollens	□Foo		Stinging Insects		
	n "Yes" answers below. C	ircle questions you don't k	now the answe				
GEN 1		stricted your participation in sports		No.		Yes	1
1.	reason?	stricted your participation in sports	FOR ally		Do you regularly use a brace, orthotics, or other assistive device? Do you have a bone, muscle, or joint injury that bothers you?		
2.		ical conditions? If so, please identil	fv		24. Do any of your joints become painful, swolllen, feel warm, or look red?		-
		mia Diabetes Infection		l i	25. Do you have any history of juvenile arthritis or connective tissue disease?		-
	Other:						-
3,	Have you ever spent the night	in the hospital?			MEDICAL QUESTIONS	Yes	
4.	Have you ever had surgery?	a in a superson construction of the superson o		min lan capaian	26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		_
		JT YOU early passed out DURING or AFTE		No.	27. Have you ever used an inhaler or taken asthma medicine?		_
5.	exercise?	early passed out DURING of AFTE	- N		Is there anyone in your family who has asthma? Were you born without or are you missing a kidney, an eye, a testicle (males),		
6.		pain, tightness, or pressure in you	r chest		your spleen, or any other organ?		
	during exercise?	pant, lightinose, or product out you	i onest		30. Do you have groin pain or a painful bulge or hernia in the groin area?		
7.	Does your heart ever race or s	kip beats (irregular beats) during e	xercise?		31. Have you had infectious mononucleosis (mono) within the past month?		
8,	Has a doctor ever told you that	you have any heart problems? If s	o, check		32. Do you have any rashes, pressure sores, or other skin problems?		_
	all that apply:			1 1	33. Have you had a herpes (cold sores) or MRSA (staph) skin infection?		-
	☐ High blood pressure	□ A heart murmur			34. Have you ever had a head injury or concussion?		_
	☐ High cholesterol	A heart infection	, a		35. Have you ever had a hit or blow to the head that caused confusion,		
	☐ Kawasaki disease	Other:		\perp	prolonged headaches, or memory problems?		_
9.		st for your heart? (For example, EC	CG/EKG,		36. Do you have a history of seizure disorder or epilepsy?		_
10.	echocardiogram)	more short of breath than expected	d during		Do you have headaches with exercise? 38. Have you ever had numbness, tingling, or weakness in your arms or		
IŲ.	exercise?	more short or pream man expected	a during		legs after being hit or falling?		-
11.	Have you ever had an unexpla	ined seizure?		+	39. Have you ever been unable to move your arms or legs after being hit or falling?		4
12.		of breath more quickly than your fri	iends		40. Have you ever become iff white exercising in the heat?		۲
	during exercise?				41. Do you get frequent muscle cramps when exercising?		+
HEA	RT HEALTH QUESTIONS ABO	UT YOUR FAMILY	Yes	No.	42. Do you or someone in your family have sickle cell trait or disease?		7
13.		tive died of heart problems or had			43. Have you had any problems with your eyes or vision?		
		dden death before age 50 (includin			44. Have you had an eye injury?		_
		ident, or sudden infant death syndr	<u> </u>		45. Do you wear glasses or contact lenses?		_
14.		ve hypertrophic cardiomyopathy, M nt ventricular cardiomyopathy, long			46. Do you wear protective eyewear, such as goggles or a face shield? 47. Do you worry about your weight?		4
		, Bruqada syndrome, or catecholar			48. Are you trying to gain or lose weight? Has anyone recommended that you do?		4
	polymorphic ventricular tachyo	ardia?			49. Are you on a special diet or do you avoid certain types of foods?		
15.	Does anyone in your family ha	ve a heart problem, pacemaker, or	implanted	+	50. Have you ever had an eating disorder?		-
	defibrillator?				51. Do you have any concerns that you would like to discuss with a doctor?		-
16.		unexplained fainling, unexplained	seizures,		FEMALES ONLY	artier,	, P
	or near drowning?		ren arendo de de la	cate tame time	52. Have you ever had a menstrual period?		
17.		a bone, muscle, ligament, or tendo		s No	53. How old were you when you had your first menstrual period?		
17.	caused you to miss a practice		on that		54. How many periods have you had in the last 12 months?		_
18.		or fractured bones or dislocated jo	ints?	+	Explain "yes" answers here		
19.		at required x-rays, MRI, CT scan, i		\dashv			
	therapy, a brace, a cast, or cru						_
20.	Have you ever had a stress from						-
21.	Have you ever been told that	ou have or have you had an x-ray					-
		ility? (Down syndrome or dwarfism					_
							Τ



Ohio High School Athletic Association



PREPARTICIPATION PHYSICAL EVALUATION 2018-2019 THE ATHLETE WITH SPECIAL NEEDS - SUPPLEMENTAL HISTORY FORM

Page 2 of 6

	Date of birth
Age Grade School	
. Type of disability	
Date of disability	MI WHITE WATER TO THE TOTAL TOT
Classification (if available)	
Cause of disability (birth, disease, accident/trauma, other)	
List the sports you are interested in playing	
	Yes No
i. Do you regularly use a brace, assistive device or prosthetic?	
Do you use a special brace or assistive device for sports?	
Do you have any rashes, pressure sores, or any other skin problems?	
Do you have a hearing loss? Do you use a hearing aid?	
. Do you have a visual impairment?	
Do you have any special devices for bowel or bladder function?	
Do you have burning or discomfort when urinaling?	
Have you had autonomic dysreflexia?	
Have you ever been diagnosed with a heat related (hyperthermia) or cold-related (hypothermia)	ermia) illness?
Do you have muscle spasticity?	
Do you have frequent seizures that cannot be controlled by medication?	
ease indicate if you have ever had any of the following.	
	Yes No
tlantoaxial instability	No. =
atlantoaxiat instability -ray evaluation for atlantoaxial instability	No No
atlantoaxial instability -ray evaluation for atlantoaxial instability islocated joints (more than one)	No.
tlantoaxial instability -ray evaluation for atlantoaxial instability islocated joints (more than one) asy bleeding	Yes No.
tlantoaxial instability -ray evaluation for atlantoaxial instability islocated joints (more than one) asy bleeding nlarged spleen	Yes No
tlantoaxial instability -ray evaluation for atlantoaxial instability islocated joints (more than one) asy bleeding nlarged spleen epatitis	No.
tlantoaxial instability -ray evaluation for atlantoaxial instability islocated joints (more than one) asy bleeding nlarged spleen lepatitis isteopenia or osteoporosis	Yes No
tlantoaxial instability -ray evaluation for atlantoaxial instability islocated joints (more than one) asy bleeding nlarged spleen lepatitis isteopenia or osteoporosis ifficulty controlling bowel	Yes No
tlantoaxial instability -ray evaluation for atlantoaxial instability islocated joints (more than one) asy bleeding nlarged spleen lepatitis isteopenia or osteoporosis ifficulty controlling bowel ifficulty controlling bladder	No.
tlantoaxial instability -ray evaluation for atlantoaxial instability islocated joints (more than one) asy bleeding nlarged spleen lepatitis isteopenia or osteoporosis ifficulty controlling bowel	No.
tlantoaxial instability -ray evaluation for atlantoaxial instability islocated joints (more than one) asy bleeding nlarged spleen lepatitis isteopenia or osteoporosis ifficulty controlling bowel iifficulty controlling bladder tumbness or tingling in arms or hands	Yes No.
tlantoaxial instability -ray evaluation for atlantoaxial instability islocated joints (more than one) asy bleeding nlarged spleen lepatitis isteopenia or osteoporosis ifficulty controlling bowel iifficulty controlling bladder lumbness or lingling in arms or hands lumbness or tingling in legs or feet	Yes No
tlantoaxial instability -ray evaluation for atlantoaxial instability islocated joints (more than one) asy bleeding nlarged spleen lepatitis Isteopenia or osteoporosis ifficulty controlling bowel itificulty controlling bladder tumbness or tingling in arms or hands tumbness or tingling in legs or feet veakness in arms or hands	Yes No
tlantoaxial instability -ray evaluation for atlantoaxial instability islocated joints (more than one) asy bleeding nlarged spleen lepatitis Isteopenia or osteoporosis ifficulty controlling bowel ifficulty controlling bladder lumbness or tingling in arms or hands lumbness or tingling in legs or feet Veakness in arms or hands Veakness in legs or feet	Yes No
Itlantoaxial instability -ray evaluation for atlantoaxial instability islocated joints (more than one) asy bleeding nlarged spleen lepatitis Isteopenia or osteoporosis iifficulty controlling bladder lumbness or tingling in arms or hands lumbness or tingling in legs or feet Weakness in arms or hands Veakness in legs or feet lecent change in coordination	Yes No
Itlantoaxial instability -ray evaluation for atlantoaxial instability islocated joints (more than one) asy bleeding nlarged spleen lepatitis Islocated joints (more than one) asy bleeding nlarged spleen lepatitis Islocated processes It is in the spleen It is	Yes No
Itlantoaxial instability -ray evaluation for attantoaxial instability islocated joints (more than one) asy bleeding nlarged spleen lepatitis Isteopenia or osteoporosis ifficulty controlling bowel itificulty controlling bladder lumbness or tingling in arms or hands lumbness or tingling in legs or feet Weakness in arms or hands Weakness in legs or feet Recent change in coordination Recent change in sbility to walk ipina bifida	Yes No
Itlantoaxial instability -ray evaluation for attantoaxial instability islocated joints (more than one) asy bleeding nlarged spleen lepatitis Isteopenia or osteoporosis ifficulty controlling bowel itificulty controlling bladder fumbness or tingling in arms or hands fumbness or tingling in legs or feet Weakness in arms or hands Veakness in legs or feet lecent change in coordination lecent change in sbility to walk ipina bifida atex altergy	Yes No
Itlantoaxial instability -ray evaluation for attantoaxial instability islocated joints (more than one) asy bleeding nlarged spleen lepatitis Isteopenia or osteoporosis ifficulty controlling bowel itificulty controlling bladder fumbness or tingling in arms or hands fumbness or tingling in legs or feet Weakness in arms or hands Veakness in legs or feet lecent change in coordination lecent change in sbility to walk ipina bifida atex altergy	Yes No
Itlantoaxial instability -ray evaluation for attantoaxial instability islocated joints (more than one) asy bleeding nlarged spleen lepatitis Isteopenia or osteoporosis ifficulty controlling bowel itificulty controlling bladder fumbness or tingling in arms or hands fumbness or tingling in legs or feet Weakness in arms or hands Veakness in legs or feet lecent change in coordination lecent change in sbility to walk ipina bifida atex altergy	Yes No
Itlantoaxial instability -ray evaluation for attantoaxial instability islocated joints (more than one) asy bleeding nlarged spleen lepatitis Isteopenia or osteoporosis ifficulty controlling bowel itificulty controlling bladder fumbness or tingling in arms or hands fumbness or tingling in legs or feet Weakness in arms or hands Veakness in legs or feet lecent change in coordination lecent change in sbility to walk ipina bifida atex altergy	Yes No



Ohio High School Athletic Association



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PREPARTICIPATION PHYSICAL EVALUATION 2018-2019

PHYSICAL EXAMINATION FORM

ame	Date of birth
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PHYSICIAN REMINDERS

- 1. Consider additional questions on more sensitive issues.
- Do you feel stressed out or under a lot of pressure?
- · Do you ever feel sad, hopeless, depressed or anxious?
- . Do you feel safe at your home or residence?
- Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
- . During the past 30 days, did you use chewing tobacco, snuff, or dip?
- . Do you drink alcohol or use any other drugs?
- · Have you ever taken anabolic steroids or used any other performance supplement?
- Have you ever taken any supplements to help you gain or lose weight or improve your performance?
- . Do you wear a seat belt, use a helmet or use condoms?
- Do you consume energy drinks?
- 2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATI	ON	. Dec						DATE OF E)	CAMINATION	l				
Height					Weight				Male	☐ Female				
BP	1	(I)	Pulse		Vision R 20/	<u>'</u> [.20/	Correc			□N	
MEDICAL	A. Palžėnainė Jasukot princijanos ir 188								NORMAL		ABNORMA	L FINI	DINGS	dian na
Appearance)													
Marfan sti	igmata (kyphosc	oliosis, h	igh-arch	ed pala	ite, pectus exc	avatum, araci	hnodactyly,							
arm span	> height, hyperla	axity, my	opia, MV	P, aort	lic insufficiency	')								
Eyes/ears/n	ose/throat													
Pupils eq	ual													
Hearing														
Lymph node	es													
Heart														
!	(auscultation sta				alva)									
Location	of the point of m	aximal in	npulse (l	PMI)										
Pulses														
Simultan	eous femoral an	d radial p	ulses							<u> </u>				
Lungs							<u> </u>							
Abdomen														
Genitourina	ry (males only)													
Skin														
HSV, le	sions suggesti	ive of M	RSA, tir	nea co	rporis			, ,						
Neurologi	С													····
MUSCULO	SKELETAL													
Neck														
Back														
Shoulder/	arm													
Elbow/fore	earm													
Wrist∕han	d/fingers													
Hip/thigh														=
Knee														
Leg/ánkle														
Foot/toes		,												
Functiona			•••											
Duck w	alk, single leg	hop								1				

^aConsider ECG, echocardiogram, or referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third part present is recommended.

^{*}Consider cognitive or baseline neuropsychiatric testing if a history of significant concussion.

PREPARTICIPATION PHYSICAL EVALUATION 2018-2019

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CLEARANCE FORM

Note: Authorization forms (pages 5 and 6) must be signed by both the parent/guardian and the student. Name Sex ☐ M ☐ F Age Date of birth Cleared for all sports without restriction ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for □ Not Cleared ☐ Pending further evaluation □ For any sports ☐ For certain sports ______ Recommendations_ I have examined the above-named student and completed the pre-participation physical evaluation. The student does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents, in the event that the examination is conducted en masse at the school, the school administrator shall retain a copy of the PPE. If conditions arise after the student has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians). Name of physician or medical examiner (print/type) ______Phone _____ Address Signature of physician/medical examiner ______, MD, DO, D.C., P.A. or A.N.P. **EMERGENCY INFORMATION** Personal Physician _____ Phone In case of Emergency, contact ______ Phone _____ Allergies_____ Other Information _____

_____ ("Student"), as described below, to

PREPARTICIPATION PHYSICAL EVALUATION 2018-2019

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 2018-2019

I hereby authorize the release and disclosure of the personal health information of ____

("School").
The information described below may be released to the School principal or assistant principal, athletic director, coach, athletic trainer, physical education teacher, school nurs 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 incurre 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' 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 car 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 stude while participating in school sponsored activities.
I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored and classroom activities, and that the School is a not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the School is covered under the federal regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.
I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student 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
1 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 2018-2019

2018-2019 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 Athlete Eligibility Guide 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.

Livil 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:
 - 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.
 - will respect the property of others.
 - will respect and obey the rules of my school and laws of my community, state and country.
 - will show respect to those who are responsible for enforcing the rules of my school and the laws of my community, state and country.
 - 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.

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.

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 to 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), residence address of the student, academic work completed, grades received and attendance data.

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.

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 4-4-1, 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 an athletic trainer working under the supervision of a physician will be required in order for the student to return to participation.

Linear read and signed the Ohio Department of Health's Concussion 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 joil 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 <u>NEVER</u> 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.





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.
- Encourage daytime naps or rest breaks when your child feels tired or worn-out.
- 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.
- Limit your child's physical activity, especially those activities where another injury or blow to the head may occur.
- Have your qualified health care professional check your child's symptoms at different times to help guide recovery.

Returning to Learn (School)

- 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
 - 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/chikt/returntoplay/

Centers for Disease Control and Prevention http://www.cdc.gov/heads.up/basks/index.html

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

Brain Injury Association of America www.biausa.org/

Returning to Play

- Returning to play is specific for each person, depending on the sport. <u>Starting 4/26/13, Ohio law requires written</u> <u>permission from a health care provider before an athlete can</u> <u>return to play.</u> 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.
- 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).
- Ohio law prohibits your child from returning to a game or practice on the same day he/she was removed.
- 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 sportspecific 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.

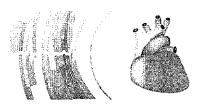
Ohio Department of Health Concussion Information Sheet For Interscholastic Athletics

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 occur.	child must have no sympt	toms before return to play can
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) a 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 view the Ohio Department of Health (ODH) video about Sudden Cardiac Arrest, review the ODH SCA handout and then sign and return this form.

Parent/Guardian Signature	Student Signature
Parent/Guardian Name (Print)	Student Name (Print)
Date	Date









John R. Kasich, Governor Stan W. Heffner, Superintendent of Public Instruction

Dear Parent(s)/Guardian,

True 205 mg Trilonal for a bandacha

Your child will be participating in an activity that will require them to be away from the OSD campus. None of the school nurses will be accompanying your child, and therefore, will not be able to assess and treat him/her.

In the event that your child is not feeling well, we are asking that you give permission for one of the non-medical chaperones to give medication. <u>Please indicate the medications and conditions</u> that you allow (most of these medications will be in generic form):

 ☐ 400 mg of Motrin/ibuprofen for physical pain, such as muscle soreness of ☐ Two chewable tablets of Pepto-Bismol for nausea/vomiting, or upset stor ☐ One Sudafed tablet for nasal congestion ☐ Two teaspoons of cough syrup or a couple of cough drops ☐ Cepastat lozenges for a sore throat. ☐ Tums; chew 1 or 2 for heartburn, indigestion 	
None of these medications, other than the throat lozenges and Tums will be given every 4 hours.	n more often than
You will be notified for any other form of illness or injury. If your child is sick of have a nurse assess the child for their assessment and recommended treatment. Verification medical person at the site, you will need to guide the chaperone in your preference.	When there is not a
If you have any questions, concerns, or restrictions, please notify us as soon as po	ossible.
Sincerely,	
Dawn Henslee, RN SHS Nursing Director	
PARENT SIGNATURE DATE	
STUDENT'S NAME ACTIVITY / SPORTS	
RETURN THIS FORM TO BILL ESTES	