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*Promoting a Culture of Collaboration, Innovation and Inspiration*

To Our Parents,

This packet you are receiving includes information for you and your child to read and **mandatory** paperwork that needs to be filled out by both of you and returned in order for your child to participate in athletics at Colonial School District. Below we have listed each document that is in this packet and what needs to be completed. The state has recently mandated through Senate Bill No.200 that this information be provided to and obtained from all participating parties.

1. *PIAA Comprehensive Initial Pre-Participation Physical Evaluation- SECTIONS 1-6 and the NEW sect 10* needs to be completed by the parent(s) and a physician, and submitted to the athletic trainer on the team's scheduled day. The physical must occur June 1<sup>st</sup> or later.
2. *Athletic Training Room Confidential Medical Information Form- (PWHS only)* needs to be completed by the parent(s) and returned to the athletic trainer on the team's scheduled day.
3. *Colonial School District Parent/Student-Athlete Concussion Statement-* must be filled out by both the parent(s) and student-athlete after reading the fact sheets enclosed and returned to the athletic trainer on the team's scheduled day.
4. *Colonial School District Student Emergency Information Card-* needs to be completed by the parent(s) and returned to the athletic trainer on the team's scheduled day.
5. *Colonial School District Concussion Return to Play Protocol-* must be reviewed by both the parent(s) and student.
6. *Colonial School District Concussion Return to Play Protocol (for physicians) -* this form must be brought to the treating physician and signed by said physician should a concussion occur and returned to the athletic trainer.
7. *Section 8: PIAA Comprehensive Pre-Participation Physical Re-Certification By Licensed Physician Of Medicine Or Osteopathic Medicine-* must be filled out by the treating physician after an injury or concussion and returned to the athletic trainer.
8. *Heads Up to Schools: Know Your Concussion ABCs, A Fact Sheet for Parents-* must be reviewed by the parent(s).
9. *Facts about Concussion and Brain injury-* must be reviewed by both the parent(s) and student-athlete.
10. *Heads Up Concussion in High School Sports, A Fact Sheet for Athletes-* must be reviewed by the student-athlete.

**\* Please turn over\***

11. *ImPACT Introduction*- Must be reviewed by the parent(s).

We understand that this packet includes a lot of information and paperwork, but it is all necessary in order to give your child the best care.

Thank you for taking the time to read and complete these forms.

Colonial School District



**PIAA COMPREHENSIVE INITIAL  
PRE-PARTICIPATION PHYSICAL EVALUATION**



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

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

**SECTION 1: PERSONAL AND EMERGENCY INFORMATION**

**PERSONAL INFORMATION**

Student's Name \_\_\_\_\_ Male Female (check one)  
 Date of Student's Birth: \_\_\_/\_\_\_/\_\_\_\_ Age of Student on Last Birthday: \_\_\_ Grade for Current School Year: \_\_\_  
 Current Physical Address \_\_\_\_\_  
 Current Home Phone # ( ) \_\_\_\_\_ Parent/Guardian Current Cellular Phone # ( ) \_\_\_\_\_  
 Fall Sport(s): \_\_\_\_\_ Winter Sport(s): \_\_\_\_\_ Spring Sport(s): \_\_\_\_\_

**EMERGENCY INFORMATION**

Parent's/Guardian's Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ Emergency Contact Telephone # ( ) \_\_\_\_\_  
 Secondary Emergency Contact Person's Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ Emergency Contact Telephone # ( ) \_\_\_\_\_  
 Medical Insurance Carrier \_\_\_\_\_ Policy Number \_\_\_\_\_  
 Address \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_  
 Family Physician's Name \_\_\_\_\_, MD DO (check one)  
 Address \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_  
 Student's Allergies \_\_\_\_\_  
 Student's Health Condition(s) of Which an Emergency Physician or Other Medical Personnel Should be Aware \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Student's Prescription Medications and conditions of which they are being prescribed \_\_\_\_\_  
 \_\_\_\_\_

**SECTION 2: CERTIFICATION OF PARENT/GUARDIAN**

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

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

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

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

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

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

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

#### What is a concussion?

A concussion is a brain injury that:

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

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

#### What are the symptoms of a concussion?

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

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

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

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

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

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

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

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

Student's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## SECTION 4: UNDERSTANDING OF SUDDEN CARDIAC ARREST & COVID-19 SYMPTOMS AND WARNING SIGNS

### What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

### How common is sudden cardiac arrest in the United States?

There are about 350,000 cardiac arrests that occur outside of hospitals each year. More than 10,000 individuals under the age of 25 die of SCA each year. SCA is the number one killer of student athlete and the leading cause of death on school campuses.

### Are there warning signs?

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

- Dizziness or lightheadedness when exercising;
- Fainting or passing out during or after exercising;
- Shortness of breath or difficulty breathing with exercise, not asthma related;
- Racing, skipped beats or fluttering heartbeat (palpitations)
- Fatigue (extreme or recent onset of tiredness)
- Weakness; and/or
- Chest pains/pressure or tightness during or after exercise.

These symptoms can be unclear and confusing in athletes. Some may ignore the signs or think they are normal from physical exhaustion. If the conditions that cause SCA are diagnosed and treated before a life-threatening event, sudden cardiac death can be prevented in many young athletes.

### What are the risks of practicing or playing after experiencing these symptoms?

There are risks associated with continuing to practice or play after experiencing these symptoms. The symptoms might mean something is wrong with the athlete and they should be checked before returning to play. When the heart stops due to cardiac arrest, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who experience a SCA die from it; survival rates are below 10%.

### Act 73 – Peyton's Law - Electrocardiogram Testing for Student Athletes

The Act is intended to keep student-athletes safe while practicing or playing. Please review the warning signs/symptoms and know that you can request, at your expense, an electrocardiogram (EKG or ECG) to help uncover hidden heart issues that can lead to SCA.

### Why Do Heart Conditions That Put Youth at Risk Go Undetected?

- Up to 90 percent of underlying heart issues are missed when using only the history and physical exam;
- Most heart conditions that can lead to SCA are not detectable by listening to the heart with a stethoscope during a routine physical; and
- Often, youth don't report or recognize symptoms of a potential heart condition.

### What is an Electrocardiogram (EKG or ECG)?

An ECG/EKG is a quick, painless and noninvasive test that measures and records a moment in time of the heart's electrical activity. Small electrode patches are attached to the skin of your chest, arms and legs by a technician. An ECG/EKG provides information about the structure, function, rate and rhythm of the heart.

### Why Add an ECG/EKG to the Physical Examination?

Adding an ECG/EKG to the history and physical exam can suggest further testing or help identify up to two-thirds of heart conditions that can lead to SCA. An ECG/EKG can be ordered by your physician for screening for cardiovascular disease (**ICD 10 code: Z13.6**) or for a variety of symptoms such as chest pain, palpitations, dizziness, fainting, or family history of heart disease and will generally be paid for by insurance.

- ECG/EKG screenings should be considered every 1-2 years because young hearts grow and change.
- ECG/EKG screenings may increase sensitivity for detection of undiagnosed cardiac disease but may not prevent SCA.
- ECG/EKG screenings with abnormal findings will need to be evaluated by trained physicians.
- If the ECG/EKG screening has abnormal findings, additional testing may need to be done (with associated cost and risk) before a diagnosis can be made, and may prevent the student from participating in sports for a short period of time until the testing is completed and more specific recommendations can be made.
- The ECG/EKG can have false positive findings, suggesting an abnormality that does not really exist after more testing (false positive findings occur less than 3% of the time when ECG/EKGs are read by a medical practitioner proficient in ECG/EKG interpretation of children, adolescents and young athletes.).
- ECGs/EKGs result in fewer false positives than the current history and physical exam (10%).

The American College of Cardiology/American Heart Association guidelines do not recommend an ECG or EKG in **asymptomatic** patients but do support local programs in which ECG or EKG can be applied with high-quality resources.

#### *Removal from play/return to play*

Any student-athlete who has signs or symptoms of SCA must be removed from play. The symptoms can happen before, during, or after activity. Play includes all athletic activity.

Before returning to play, the athlete must be evaluated. Clearance to return to play must be in writing. The evaluation must be performed by a licensed physician, certified registered nurse practitioner, or cardiologist (heart doctor). The licensed physician or certified registered nurse practitioner may consult any other licensed or certified medical professionals.

I have reviewed this form and understand the symptoms and warning signs of SCA. I have also read the information about the electrocardiogram testing and how it may help to detect hidden heart issues.

_____ Signature of Student-Athlete	_____ Print Student-Athlete's Name	Date ____/____/____
_____ Signature of Parent/Guardian	_____ Print Parent/Guardian's Name	Date ____/____/____

**SECTION 5: HEALTH HISTORY**

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

<p>1. Has a doctor ever denied or restricted your participation in sport(s) for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Do you have an ongoing medical condition (like asthma or diabetes)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you have allergies to medicines, pollens, foods, or stinging insects? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever passed out or nearly passed out DURING exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you ever passed out or nearly passed out AFTER exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever had discomfort, pain, or pressure in your chest during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Does your heart race or skip beats during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Has a doctor ever told you that you have (check all that apply):</p> <p><input type="checkbox"/> High blood pressure      <input type="checkbox"/> Heart murmur      <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> High cholesterol      <input type="checkbox"/> Heart infection      <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Has anyone in your family died for no apparent reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Does anyone in your family have a heart problem? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Does anyone in your family have Marfan Syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Have you ever spent the night in a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <div style="border: 1px solid black; padding: 5px;"> <p>17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a Practice or Contest? If yes, check affected area below: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, check below: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </div> <table border="0" style="width: 100%; font-size: small;"> <tr> <td>Head</td> <td>Neck</td> <td>Shoulder</td> <td>Upper arm</td> <td>Elbow</td> <td>Forearm</td> <td>Hand/ Fingers</td> <td>Chest</td> </tr> <tr> <td>Upper back</td> <td>Lower back</td> <td>Hip</td> <td>Thigh</td> <td>Knee</td> <td>Calf/shin</td> <td>Ankle</td> <td>Foot/ Toes</td> </tr> </table> <p>20. Have you ever had a stress fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Do you regularly use a brace or assistive device? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ Fingers	Chest	Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ Toes	<p>23. Has a doctor ever told you that you have asthma or allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Is there anyone in your family who has asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Have you ever used an inhaler or taken asthma medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28. Have you had infectious mononucleosis (mono) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>29. Do you have any rashes, pressure sores, or other skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>30. Have you ever had a herpes skin infection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <div style="border: 1px solid black; padding: 5px;"> <p><b>CONCUSSION OR TRAUMATIC BRAIN INJURY</b></p> <p>31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>32. Have you been hit in the head and been confused or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>33. Do you experience dizziness and/or headaches with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </div> <p>34. Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>36. Have you ever been unable to move your arms or legs after being hit or falling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>37. When exercising in the heat, do you have severe muscle cramps or become ill? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>39. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>40. Do you wear glasses or contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>41. Do you wear protective eyewear, such as goggles or a face shield? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>42. Are you unhappy with your weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>43. Are you trying to gain or lose weight? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>44. Has anyone recommended you change your weight or eating habits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>45. Do you limit or carefully control what you eat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>46. Do you have any concerns that you would like to discuss with a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>FEMALES ONLY</b></p> <p>47. Have you ever had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>48. How old were you when you had your first menstrual period? _____</p> <p>49. How many periods have you had in the last 12 months? _____</p> <p>50. Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ Fingers	Chest										
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ Toes										

#s	Explain "Yes" answers here:

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

Student's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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

Student's Name \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Enrolled in \_\_\_\_\_ School Sport(s) \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body Fat (optional) \_\_\_\_\_ Brachial Artery BP \_\_\_\_/\_\_\_\_ (\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_) RP \_\_\_\_\_

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

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

Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: YES NO (check one) Pupils: Equal \_\_\_\_ Unequal \_\_\_\_

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

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

**CLEARED**  **CLEARED** with recommendation(s) for further evaluation or treatment for: \_\_\_\_\_

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

COLLISION  CONTACT  NON-CONTACT  STRENUOUS  MODERATELY STRENUOUS  NON-STRENUOUS

Due To \_\_\_\_\_

Recommendation(s)/Referral(s) \_\_\_\_\_

AME's Name (print/type) \_\_\_\_\_ License # \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

AME's Signature \_\_\_\_\_ MD DO PAC CRNP SNP (check one) Certification Date of CIPPE \_\_\_\_/\_\_\_\_/\_\_\_\_

**Section 10: 2020-2021 SUPPLEMENTAL ACKNOWLEDGEMENT, WAIVER AND RELEASE: COVID-19**

The COVID-19 pandemic presents athletes with a myriad of challenges concerning this highly contagious illness. Some severe outcomes have been reported in children, and even a child with a mild or even asymptomatic case of COVID-19 can spread the infection to others who may be far more vulnerable.

While it is not possible to eliminate all risk of being infected with or furthering the spread of COVID-19, PIAA has urged all member schools to take necessary precautions and comply with guidelines from the federal, state, and local governments, the CDC and the PA Departments of Health and Education to reduce the risks to athletes, coaches, and their families. As knowledge regarding COVID-19 is constantly changing, PIAA reserves the right to adjust and implement precautionary methods as necessary to decrease the risk of exposure to athletes, coaches and other involved persons. Additionally, each school has been required to adopt internal protocols to reduce the risk of transmission.

The undersigned acknowledge that they are aware of the highly contagious nature of COVID-19 and the risks that they may be exposed to or contract COVID-19 or other communicable diseases by permitting the undersigned student to participate in interscholastic athletics. We understand and acknowledge that such exposure or infection may result in serious illness, personal injury, permanent disability or death. We acknowledge that this risk may result from or be compounded by the actions, omissions, or negligence of others. The undersigned further acknowledge that certain vulnerable individuals may have greater health risks associated with exposure to COVID-19, including individuals with serious underlying health conditions such as, but not limited to: high blood pressure, chronic lung disease, diabetes, asthma, and those whose immune systems that are compromised by chemotherapy for cancer, and other conditions requiring such therapy. While particular recommendations and personal discipline may reduce the risks associated with participating in athletics during the COVID-19 pandemic, these risks do exist. Additionally, persons with COVID-19 may transmit the disease to others who may be at higher risk of severe complications.

By signing this form, the undersigned acknowledge, after having undertaken to review and understand both symptoms and possible consequences of infection, that we understand that participation in interscholastic athletics during the COVID-19 pandemic is strictly voluntary and that we agree that the undersigned student may participate in such interscholastic athletics. The undersigned also understand that student participants will, in the course of competition, interact with and likely have contact with athletes from their own, as well as other, schools, including schools from other areas of the Commonwealth. Moreover, they understand and acknowledge that our school, PIAA and its member schools cannot guarantee that transmission will not occur for those participating in interscholastic athletics.

NOTWITHSTANDING THE RISKS ASSOCIATED WITH COVID-19, WE ACKNOWLEDGE THAT WE ARE VOLUNTARILY ALLOWING STUDENT TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS WITH KNOWLEDGE OF THE DANGER INVOLVED. WE HEREBY AGREE TO ACCEPT AND ASSUME ALL RISKS OF PERSONAL INJURY, ILLNESS, DISABILITY AND/OR DEATH RELATED TO COVID-19, ARISING FROM SUCH PARTICIPATION, WHETHER CAUSED BY THE NEGLIGENCE OF PIAA OR OTHERWISE.

We hereby expressly waive and release any and all claims, now known or hereafter known, against the student’s school, PIAA, and its officers, directors, employees, agents, members, successors, and assigns (collectively, "**Releasees**"), on account of injury, illness, disability, death, or property damage arising out of or attributable to Student’s participation in interscholastic athletics and being exposed to or contracting COVID-19, whether arising out of the negligence of PIAA or any Releasees or otherwise. We covenant not to make or bring any such claim against PIAA or any other Releasee, and forever release and discharge PIAA and all other Releasees from liability under such claims.

Additionally, we shall defend, indemnify, and hold harmless the student’s school, PIAA and all other Releasees against any and all losses, damages, liabilities, deficiencies, claims, actions, judgments, settlements, interest, awards, penalties, fines, costs, or expenses of whatever kind, including attorney fees, fees, and the costs of enforcing any right to indemnification and the cost of pursuing any insurance providers, incurred by/awarded against the student’s school, PIAA or any other Releasees in a final judgment arising out or resulting from any claim by, or on behalf of, any of us related to COVID-19.

We willingly agree to comply with the stated guidelines put forth by the student’s school and PIAA to limit the exposure and spread of COVID-19 and other communicable diseases. We certify that the student is, to the best of our knowledge, in good physical condition and allow participation in this sport at our own risk. By signing this Supplement, we acknowledge that we have received and reviewed the student’s school athletic plan.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Student Print Student’s Name

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

**ATHLETIC TRAINING ROOM**  
CONFIDENTIAL MEDICAL INFORMATION FORM

SPORT \_\_\_\_\_

SCHOOL YEAR \_\_\_\_\_

ATHLETE'S NAME \_\_\_\_\_  
(LAST) (FIRST) (M.I.)

GRADE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_

PARENT/ GUARDIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_  
(STREET) (TOWN) (ZIP)

HOME PHONE # \_\_\_\_\_

PARENT/ GUARDIAN 1 WORK # \_\_\_\_\_

PARENT/ GUARDIAN 2 WORK # \_\_\_\_\_

PARENT/ GUARDIAN 1 CELL # \_\_\_\_\_

PARENT/ GUARDIAN 2 CELL # \_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY (OTHER THAN LISTED ABOVE)

NAME \_\_\_\_\_

HOME# \_\_\_\_\_ WORK # \_\_\_\_\_ CELL # \_\_\_\_\_

MEDICAL HISTORY

ALLERGIES (MEDICAL, FOOD, ETC.) \_\_\_\_\_

MEDICATION CURRENTLY TAKING \_\_\_\_\_

CHRONIC ILLNESS/INJURY \_\_\_\_\_

WEARS PROTECTIVE: BRACE, GLASSES, CONTACTS \_\_\_\_\_

PRIOR # OF CONCUSSIONS \_\_\_\_\_

DATE OF LAST CONCUSSION \_\_\_\_\_

FAMILY PRYSICIAN \_\_\_\_\_ PHONE# \_\_\_\_\_

\_\_\_\_\_ I DO GIVE PERMISSION FOR THE CERTIFIED ATHLETIC TRAINER TO GIVE MY CHILD OVER THE COUNTER MEDICATIONS (*Advil, Tylenol, Benadryl, Tums, Pepto-Bismol, Immodium, etc.*)

\_\_\_\_\_ I DO NOT GIVE MY PERMISSION

\_\_\_\_\_  
(DATE)

\_\_\_\_\_  
(PARENT/GUARDIAN SIGNATURE)

**Colonial School District  
Parent/Guardian/Student-Athlete Concussion Statement**

Both the student-athlete and parent/guardian must initial each of the statements below.  
(P=Parent/Guardian, A=Student-athlete)

P      A

\_\_\_ \_\_\_ I understand that it is my responsibility to report all injuries and illnesses to my athletic trainer and coach.

\_\_\_ \_\_\_ I have read and understand the Concussion Information Packet.

\_\_\_ \_\_\_ I have read and understand that the ImPACT program is a mandatory part of participating in athletics at Colonial School District and I give consent for my child to undergo ImPACT testing.

\_\_\_ \_\_\_ I understand if my child sustains a concussion he/she must have written clearance on both the Return to Play Protocol (physician's copy) and the Section 7 of the PIAA physical forms by an appropriate physician, along with a return to baseline score on the ImPACT post-test, and completion of the Return to Play Protocol.

\_\_\_ \_\_\_ A concussion is a brain injury, which I am responsible for reporting to my athletic trainer and coach.

After reading the information on concussions, I am aware of the following information:  
(Initial on provided lines.)

P      A

\_\_\_ \_\_\_ A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep, and classroom performance.

\_\_\_ \_\_\_ A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep, and classroom performance.

\_\_\_ \_\_\_ You cannot see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.

\_\_\_ \_\_\_ If I suspect a teammate has a concussion, I should report the injury to my athletic trainer and coach.

\_\_\_ \_\_\_ I will not return to play in a game or practice 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 a repeat concussion if you return to play before your symptoms resolve.

\_\_\_ \_\_\_ In rare cases, repeat concussions can cause permanent brain damage, and even death.

Signature of Student-Athlete

Printed name of Student-Athlete

Date

Signature of Parent/Guardian

Printed name of Parent/Guardian

Date

COLONIAL SCHOOL DISTRICT  
STUDENT-ATHLETE EMERGENCY INFORMATION

Name of Pupil	Last	First	M.I.	Age	Date of Birth
Address					Home Phone
Parent/Guardian 1's Name			Work Phone		Cell Phone
Parent/Guardian 2's Name			Work Phone		Cell Phone
Name of Person to Call in Emergency If Parent Cannot Be Reached					Phone
Medical Problems or Allergies					
Family Physician					Phone

\_\_\_\_\_  
Parent/Guardian Signature

\*\*\* COMPLETED FORM REQUIRED FOR SPORT PARTICIPATION\*\*\*\*\*

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## Colonial School District Concussion Return to Play Protocol

The Colonial School District Concussion Return to Play Progression follows these steps:

1. Computerized neurocognitive testing will be administered at the timing and direction of the Certified Athletic Trainer.
2. Referral to a doctor that is trained in concussion care per Senate Bill No. 200 or our team sports medicine physicians at Drexel Sports Medicine, for clearance with stipulation of the following return to play progression.
3. Symptom free at rest without medication for a minimum of two full days, including at least one full school day, and a return to baseline scores on the post injury computerized neurocognitive testing. The athlete reports to Athletic Trainer daily to document symptoms.
4. Bike exercise test.
5. Exertion workout following 24 hours symptom free post bike workout.
6. Non contact practice following 24 hours symptom free post exertion workout.
7. Contact practice following 24 hours symptom free post non contact practice.
8. Full return to sport following 24 hours symptom free post contact practice.

This is a general outline of Concussion Return to Play and each concussion should be handled on an individual basis. Time between steps may vary depending on the individual, number of previous concussions and other factors, and physician recommendations. If any symptoms arise during any one of the steps, the athlete returns to step one.

Drexel University College of Medicine  
Drexel Sports Medicine  
10 Shurs Lane, Suite 206  
Philadelphia, PA 19127  
215-482-1234

**Colonial School District  
Concussion Return to Play Protocol  
(For physicians)**

The Colonial School District Concussion Return to Play Progression follows these steps:

1. Computerized neurocognitive testing will be administered at the timing and direction of the Certified Athletic Trainer.
2. Referral to a doctor that is trained in concussion care per Senate Bill No. 200 or our team sports medicine physicians at Drexel Sports Medicine, for clearance with stipulation of the following return to play progression.
3. Symptom free at rest without medication for a minimum of two full days, including at least one full school day, and a return to baseline scores on the post injury computerized neurocognitive testing. The athlete reports to Athletic Trainer daily to document symptoms.
4. Bike exercise test.
5. Exertion workout following 24 hours symptom free post bike workout.
6. Non contact practice following 24 hours symptom free post exertion workout.
7. Contact practice following 24 hours symptom free post non contact practice.
8. Full return to sport following 24 hours symptom free post contact practice.

This is a general outline of Concussion Return to Play and each concussion should be handled on an individual basis. Time between steps may vary depending on the individual, number of previous concussions and other factors, and physician recommendations. If any symptoms arise during any one of the steps, the athlete returns to step one.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

**Section 8: Re-CERTIFICATION BY LICENSED PHYSICIAN OF MEDICINE OR OSTEOPATHIC MEDICINE**

This Form must be completed for any student who, subsequent to completion of Sections 1 through 6 of this CIPPE Form, required medical treatment from a licensed physician of medicine or osteopathic medicine. This Section 8 may be completed at any time following completion of such medical treatment. Upon completion, the Form must be turned in to the Principal, or the Principal's designee, of the student's school, who, pursuant to ARTICLE X, LOCAL MANAGEMENT AND CONTROL, Section 2, Powers and Duties of Principal, subsection C, of the PIAA Constitution, shall "exclude any contestant who has suffered serious illness or injury until that contestant is pronounced physically fit by the school's licensed physician of medicine or osteopathic medicine, or if none is employed, by another licensed physician of medicine or osteopathic medicine."

**NOTE: The physician completing this Form must first review Sections 5 and 6 of the herein named student's previously completed CIPPE Form. Section 7 must also be reviewed if both (1) this Form is being used by the herein named student to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in a subsequent sport season in the same school year AND (2) the herein named student either checked yes or circled any Supplemental Health History questions in Section 7.**

**If the physician completing this Form is clearing the herein named student subsequent to that student sustaining a concussion or traumatic brain injury, that physician must be sufficiently familiar with current concussion management such that the physician can certify that all aspects of evaluation, treatment, and risk of that injury have been thoroughly covered by that physician.**

Student's Name: \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_

Enrolled in \_\_\_\_\_ School \_\_\_\_\_

Condition(s) Treated Since Completion of the Herein Named Student's CIPPE Form: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**A. GENERAL CLEARANCE:** Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with no restrictions, except those, if any, set forth in Section 6 of that student's CIPPE Form.

Physician's Name (print/type) \_\_\_\_\_ License # \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ MD DO (check one) Date \_\_\_\_\_

**B. LIMITED CLEARANCE:** Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with, in addition to the restrictions, if any, set forth in Section 6 of that student's CIPPE Form, the following limitations/restrictions:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Physician's Name (print/type) \_\_\_\_\_ License # \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ MD DO (check one) Date \_\_\_\_\_

# A Fact Sheet for HIGH SCHOOL PARENTS



This sheet has information to help protect your teens from concussion or other serious brain injury.

## What Is a Concussion?

A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move quickly back and forth. This fast movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging the brain cells.

## How Can I Help Keep My Teens Safe?

Sports are a great way for teens to stay healthy and can help them do well in school. To help lower your teens' chances of getting a concussion or other serious brain injury, you should:

- Help create a culture of safety for the team.
  - › Work with their coach to teach ways to lower the chances of getting a concussion.
  - › Emphasize the importance of reporting concussions and taking time to recover from one.
  - › Ensure that they follow their coach's rules for safety and the rules of the sport.
  - › Tell your teens that you expect them to practice good sportsmanship at all times.
- When appropriate for the sport or activity, teach your teens that they must wear a helmet to lower the chances of the most serious types of brain or head injury. There is no "concussion-proof" helmet. Even with a helmet, it is important for teens to avoid hits to the head.

## How Can I Spot a Possible Concussion?

Teens who show or report one or more of the signs and symptoms listed below—or simply say they just "don't feel right" after a bump, blow, or jolt to the head or body—may have a concussion or other serious brain injury.

### Signs Observed by Parents

- Appears dazed or stunned.
- Forgets an instruction, is confused about an assignment or position, or is unsure of the game, score, or opponent.
- Moves clumsily.
- Answers questions slowly.
- Loses consciousness (*even briefly*).
- Shows mood, behavior, or personality changes.
- Can't recall events *prior to* or *after* a hit or fall.

### Symptoms Reported by Teens

- Headache or "pressure" in head.
- Nausea or vomiting.
- Balance problems or dizziness, or double or blurry vision.
- Bothered by light or noise.
- Feeling sluggish, hazy, foggy, or groggy.
- Confusion, or concentration or memory problems.
- Just not "feeling right," or "feeling down."

**Talk with your teens about concussion.** Tell them to report their concussion symptoms to you and their coach right away. Some teens think concussions aren't serious or worry that if they report a concussion they will lose their position on the team or look weak. Remind them that *it's better to miss one game than the whole season.*



Centers for Disease  
Control and Prevention  
National Center for Injury  
Prevention and Control

## GOOD TEAMMATES KNOW:

IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON.

**Concussions affect each teen differently.** While most teens with a concussion feel better within a couple of weeks, some will have symptoms for months or longer. Talk with your teens' health care provider if their concussion symptoms do not go away or if they get worse after they return to their regular activities.



## Plan ahead.

What do you want your teen to know about concussion?

## What Are Some More Serious Danger Signs to Look Out For?

In rare cases, a dangerous collection of blood (hematoma) may form on the brain after a bump, blow, or jolt to the head or body and can squeeze the brain against the skull. Call 9-1-1 or take your teen to the emergency department right away if, after a bump, blow, or jolt to the head or body, he or she has one or more of these danger signs:

- One pupil larger than the other.
- Drowsiness or inability to wake up.
- A headache that gets worse and does not go away.
- Slurred speech, weakness, numbness, or decreased coordination.
- Repeated vomiting or nausea, convulsions or seizures (shaking or twitching).
- Unusual behavior, increased confusion, restlessness, or agitation.
- Loss of consciousness (passed out/knocked out). Even a brief loss of consciousness should be taken seriously.



You can also download the CDC *HEADS UP* app to get concussion information at your fingertips. Just scan the QR code pictured at left with your smartphone.

## What Should I Do If My Teen Has a Possible Concussion?

As a parent, if you think your teen may have a concussion, you should:

1. Remove your teen from play.
2. Keep your teen out of play the day of the injury. Your teen should be seen by a health care provider and only return to play with permission from a health care provider who is experienced in evaluating for concussion.
3. Ask your teen's health care provider for written instructions on helping your teen return to school. You can give the instructions to your teen's school nurse and teacher(s) and return-to-play instructions to the coach and/or athletic trainer.

Do not try to judge the severity of the injury yourself. Only a health care provider should assess a teen for a possible concussion. You may not know how serious the concussion is at first, and some symptoms may not show up for hours or days. A teen's return to school and sports should be a gradual process that is carefully managed and monitored by a health care provider.

➤ **Teens who continue to play while having concussion symptoms or who return to play too soon—while the brain is still healing—have a greater chance of getting another concussion. A repeat concussion that occurs while the brain is still healing from the first injury can be very serious and can affect a teen for a lifetime. It can even be fatal.**

Revised 12/2015



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Control and Prevention  
National Center for Injury  
Prevention and Control

To learn more, go to [www.cdc.gov/HEADSUP](http://www.cdc.gov/HEADSUP)

# A Fact Sheet for HIGH SCHOOL ATHLETES

## HEADS UP CONCUSSION

### WHAT IS A CONCUSSION?

A concussion is a brain injury that affects how your brain works. It can happen when your brain gets bounced around in your skull after a fall or hit to the head.

This sheet has information to help you protect yourself from concussion or other serious brain injury and know what to do if a concussion occurs.

### WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?



**REPORT IT.** Tell your coach, parent, and athletic trainer if you think you or one of your teammates may have a concussion. It's up to you to report your symptoms. Your coach and team are relying on you. Plus, you won't play your best if you are not feeling well.



#### **GIVE YOUR BRAIN TIME TO HEAL.**

A concussion can make everyday activities, such as going to school, harder. You may need extra help getting back to your normal activities. Be sure to update your parents and doctor about how you are feeling.

### WHY SHOULD I TELL MY COACH AND PARENT ABOUT MY SYMPTOMS?

- Playing or practicing with a concussion is dangerous and can lead to a longer recovery.
- While your brain is still healing, you are much more likely to have another concussion. This can put you at risk for a more serious injury to your brain and can even be fatal.



Centers for Disease  
Control and Prevention  
National Center for Injury  
Prevention and Control

#### **GOOD TEAMMATES KNOW:**

IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON.

# HOW CAN I TELL IF I HAVE A CONCUSSION?

You may have a concussion if you have any of these symptoms after a bump, blow, or jolt to the head or body:

-  ..... **Get a headache**
-  ..... **Feel dizzy, sluggish or foggy**
-  ..... **Be bothered by light or noise**
-  ..... **Have double or blurry vision**
-  ..... **Vomit or feel sick to your stomach**
-  ..... **Have trouble focusing or problems remembering**
-  ..... **Feel more emotional or “down”**
-  ..... **Feel confused**
-  ..... **Have problems with sleep**

Concussion symptoms usually show up right away, but you might not notice that something “isn’t right” for hours or days. A concussion feels different to each person, so it is important to tell your parents and doctor how you are feeling.

*The information provided in this document or through linkages to other sites is not a substitute for medical or professional care. Questions about diagnosis and treatment for concussion should be directed to a physician or other health care provider.*

# HOW CAN I HELP MY TEAM?



## PROTECT YOUR BRAIN.

Avoid hits to the head and follow the rules for safe and fair play to lower your chances of getting a concussion. Ask your coaches for more tips.



**BE A TEAM PLAYER.** You play an important role as part of a team. Encourage your teammates to report their symptoms and help them feel comfortable taking the time they need to get better.



Centers for Disease Control and Prevention  
National Center for Injury Prevention and Control

To learn more, go to [www.cdc.gov/HEADSUP](http://www.cdc.gov/HEADSUP)

# Facts about Concussion and Brain Injury



## About Concussion

A concussion is a type of traumatic brain injury (TBI) caused by a bump, blow, or jolt to the head. Concussions can also occur from a fall or a blow to the body that causes the head and brain to move quickly back and forth. Doctors may describe a concussion as a “mild” brain injury because concussions are usually not life-threatening. Even so, their effects can be serious.

## Concussion Signs and Symptoms

Most people with a concussion recover quickly and fully. But for some people, symptoms can last for days, weeks, or longer. In general, recovery may be slower among older adults, young children, and teens. Those who have had a concussion in the past are also at risk of having another one and may find that it takes longer to recover if they have another concussion. Symptoms of concussion usually fall into four categories:

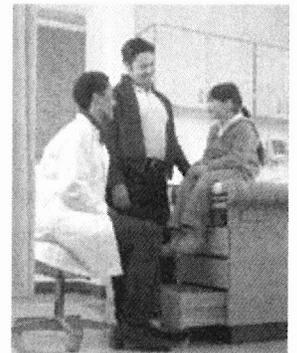
<b>Thinking/Remembering</b>	Difficulty thinking clearly	Feeling slowed down	Difficulty concentrating	Difficulty remembering new information
<b>Physical</b>	Headache Fuzzy or blurry vision	Nausea or vomiting (early on) Dizziness	Sensitivity to noise or light Balance problems	Feeling tired, having no energy
<b>Emotional/Mood</b>	Irritability	Sadness	More emotional	Nervousness or anxiety
<b>Sleep</b>	Sleeping more than usual	Sleep less than usual	Trouble falling asleep	

## Getting Better

Rest is very important after a concussion because it helps the brain to heal. Ignoring your symptoms and trying to “tough it out” often makes symptoms worse. Be patient because healing takes time. Only when your symptoms have reduced significantly, in consultation with your doctor, should you slowly and gradually return to your daily activities, such as work or school. If your symptoms come back or you get new symptoms as you become more active, this is a sign that you are pushing yourself too hard. Stop these activities and take more time to rest and recover. As the days go by, you can expect to gradually feel better.

Tips to help you get better:

- Get plenty of sleep at night, and rest during the day.
- Avoid activities that are physically demanding (e.g., sports, heavy housecleaning, working-out) or require a lot of concentration (e.g., sustained computer use, video games).
- Ask your doctor when you can safely drive a car, ride a bike, or operate heavy equipment.
- Do not drink alcohol. Alcohol and other drugs may slow your recovery and put you at risk of further injury.



There are many people who can help you and your family as you recover from a concussion. You do not have to do it alone. Keep talking with your doctor, family members, and loved ones about how you are feeling, both physically and emotionally. If you do not think you are getting better, tell your doctor.

For more information and resources, please visit CDC on the Web at: [www.cdc.gov/Concussion](http://www.cdc.gov/Concussion).



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Disease Control and Prevention



*Promoting a Culture of Collaboration, Innovation and Inspiration*

Dear Parent/ Guardian,

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

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

If a concussion is suspected, the athlete will be required to re-take the test. Both the preseason and post-injury test data is administered to help evaluate the injury. The information gathered can also be shared with your health care professional. The test data will assist these health professionals to determine when return-to-play is appropriate and safe for the injured athlete. If an injury of this nature occurs to your child, you will be promptly contacted with all the details.

I wish to stress that the ImPACT testing procedures are non-invasive, and they pose no risks to your student-athlete. We are excited to implement this program given that it provides us the best available information for managing concussions and preventing potential brain damage that can occur with multiple concussions. The Colonial School District administration, coaching, and athletic training staffs are striving to keep your child's health and safety at the forefront of the student athletic experience. Please return the attached page with the appropriate signatures. If you have any further questions regarding this program, please feel free to contact the activities director at your school.

Sincerely,

Ralph C. Bretz  
Athletic Director  
Plymouth Whitemarsh High School  
610-825-1500 x1903