Dear Parents and Athletes:

In preparation for the 2018 - 2019 athletic seasons, Mission Sports Medicine will conduct pre-participation physical exams (PPEs) on 5/22/2018 in the Highlands School Gymnasium between 2:00 and 4:00PM. Any rising 5th-12th grade student who will be, or is considering, participating in NCHSAA sanctioned sports, must undergo a state-mandated PPE.

Annual physical examinations with your primary care provider are important to your child's overall well-being, and PPEs are not a substitute for annual exams. However, pre-participation exams are important to ensure athletes are healthy for participation. Specifically, PPEs:

1. Identify medical and musculoskeletal problems that may place the athlete at risk for injury or illness
2. Identify correctable problems that may impair the athlete's ability to perform
3. Assure that any previous injuries have been adequately rehabilitated
4. Assess fitness level for specific sports
5. Provide education concerning sports, exercise, injuries and other health related issues
6. Identify medical conditions that may require further evaluation and treatment prior to participation

Prior to the PPE, parents will need to complete the following medical forms (in blue/black ink):

1. Mission Sports Medicine - Consent for Medical Care and Treatment – *initial and sign*
2. Mission Sports Medicine – Sudden Cardiac Arrest Awareness – *initial and sign*
3. Mission Sports Medicine – Medication Agent Release* - *complete and sign*
   Only required if you grant permission to the Athletic Trainer to provide certain medications to your child as needed
4. NCHSAA - Medical History Questionnaire – *complete the front page and sign*

Athletes MUST have these forms, signed and completed, with them to get their physical. Please do not bring summer camp, Scouts, or other medical forms; these types of forms will not be filled out at this time.

Parents, you are encouraged to attend the PPE to meet the Team Physicians and Athletic Trainers. Should you have any questions or concerns, please call Brett Lamb or Will Mathiowdis for assistance.

Sincerely,

Brett Lamb
Athletic Director
Highlands School
828-526-2147
brett.lamb@macon.k12.nc.us

Will Mathiowdis, MS, LAT, ATC
Athletic Trainer – Highlands School
Highlands-Cashiers Hospital
828-200-9241
William.mathiowdis@msj.org

Sports Medicine Program Consent for Medical Care and Treatment

I, ____________________, the parent/legal guardian of ________________________, a student at ________________ (the "School") whose date of birth is ________________, authorize Mission Health System, Inc. and each of its affiliated, participating hospitals as applicable including Mission Hospital, Inc., Blue Ridge Regional Hospital, Inc., Mission Hospital McDowell, Inc., Angel Medical Center, Inc., Highlands-Cashiers Hospital, Inc. and Transylvania Community Hospital, Inc. (collectively and/or individually as is applicable referred to herein as "Mission") and associated staff to provide my child such healthcare or other services offered by the Sports Medicine Program and, where appropriate, to make referrals for my child to receive additional health services that my child's condition may indicate. *In any such event, student athletes and their parents/legal guardians shall have the option to choose any medical provider as they and/or their legal guardian(s) may choose, as many options are available to student athletes. No student and/or his or her parents/guardians are required to utilize Mission for medical services.*

Pre-Participation Physical. I hereby give my consent/permission to Mission and participating, licensed or other medical providers to perform a pre-participation screening physical examination ('screening exam") for my child. I agree that this screening exam is only a limited, screening examination and does not take the place of a complete medical examination. I understand and agree that the medical provider(s) completing the screening exam shall not be responsible for any ongoing medical care or treatment for any medical condition or for injuries that occur after the screening exam. I represent, to the best of my knowledge, that my child has no known medical condition that would prevent participation in sports. I agree to follow up with my child's primary care provider in the event that any medical condition is identified in the screening exam.

Injury and/or Emergency Treatment: In the event that it becomes necessary, I agree that the team physician or athletic trainer, as appropriate, may provide medical care and/or treatment to my child as provided herein for a sports-related injury. In addition, in the event my child needs urgent or emergency treatment, I authorize the staff of the School and/or Mission, where appropriate, to arrange for such care with appropriate providers, including appropriate transportation. In such instance, I authorize the School and/or Mission, where appropriate, to undertake any acts which may be necessary or proper to provide for the health care of the minor child named herein, including, but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures. By signing below, I indicate that I have the understanding and capacity to communicate health care decisions on behalf of the child named herein and that I understand the contents of this document. I understand that the School staff and/or the Mission staff, as appropriate, will contact me as soon as possible in the event my child has an urgent or emergency condition.

Payment for Services Rendered. I understand that I will not be charged by Mission for services rendered on-site by the Mission Athletic Trainer or other Mission Sports Medicine staff assigned to the school but that I or my insurance carrier may be charged for services rendered by other healthcare providers for follow-up care or treatment.

Health Information. I agree to complete all health history, family history, and other informational requests necessary for my child's participation in the School's athletic events and as required for medical care and treatment or other services provided by Mission. I understand that I may contact the Mission Athletic Trainer or the Team Physician assigned to the School or the Mission Medical Director to discuss my child's care or to discuss any questions that I may have about the program.

Neurocognitive Testing. I understand and agree that my child may undergo a computerized concussion evaluation system, such as ImPACT, as part of an overall concussion management protocol. https://www.impacttest.com/about

Students. I understand and agree that Mission is involved in the education of student athletic trainers (at the college level and student aides at the high school level), physicians, nurses, technicians and other health care providers, interns, and observers. I understand and agree that these individuals may participate as is appropriate in providing athletic training, medical care and/or treatment to my child as provided herein for a sports-related injury or otherwise.

Medication. Athletic Trainers are not responsible for an athlete's prescription or non- prescription medication(s). An athletic trainer may, under the supervision and protocol of a provider, receive, store, and administer medication to my child and/or store my child's medication for the duration of an athletic event upon my request.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AGREE AND CONSENT TO MY CHILD'S PARTICIPATION IN THE MISSION SPORTS MEDICINE PROGRAM AND TO THE OTHER TERMS AND CONDITIONS CONTAINED HEREIN. I HEREBY CERTIFY THAT I AM THE PARENT OR LEGAL GUARDIAN OF THE CHILD NAMED HEREIN.

Name of Parent/Legal Guardian (Please Print) ______________________________

Name of Student (Please Print) ______________________________

Signature of Parent/Legal Guardian ______________________________

Relationship to Student ______________________________

Date of Signature: ______________________________

AUTHORIZATION FOR ACCESS, USE, OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ____________________, the parent/legal guardian of ________________, a student at ___________________ (the "School") whose date of birth is ____________, authorize Mission Health System, Inc. and each of its affiliated, participating hospitals as applicable including Mission Hospital, Inc., Blue Ridge Regional Hospital, Inc., Mission Hospital McDowell, Inc., Angel Medical Center, Inc., Highlands-Cashiers Hospital, Inc. and Transylvania Community Hospital, Inc. (collectively and/or individually as is applicable referred to herein as "Mission") consent to and authorize the release by Mission of information about my child's medical condition obtained through the Sports Medicine Program to the School's named coaches and other employees or agents of the School. I also specifically consent to and authorize the sharing of my child's medical information among the Mission Sports Medicine staff (team physicians, if any, other medical staff/providers, athletic trainers, and any student assistants) and the School's athletic staff, teachers/coaches, and school administration.

My signature below indicates that I understand and agree to the following:

1. This authorization for the release of my health information is voluntary, which means I do not have to authorize this release or sign this form.
2. As applicable, this release may include information related to behavioral/mental health, drug and alcohol abuse treatment, genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.
3. My decision to sign this authorization will not have an effect on the treatment provided to my child by any applicable health care provider, the cost of that treatment, or any benefits.
4. I may revoke this authorization at any time by notifying Mission in writing.
5. Revoking this authorization will not affect any disclosures made prior to revoking this authorization.
6. Unless revoked or an **expiration date** is indicated here ________, this authorization will extend until the end of the athletic season for which my child is engaged (2018~~7~~-2019~~8~~ athletic year).
7. After release my information may no longer be protected by privacy regulations, which means the person receiving may be able to share that information without my permission.
8. Mission will not use or share my health information without my permission, except as allowed or required by law.
9. This form will not be used for marketing or research.
10. A fee may be charged for providing any requested medical records.
11. I may ask for and get a copy of this authorization. A readable photocopy/fax of this authorization shall have the same force and effect as the original.

I hereby authorize the access, use or disclosure of my child's health information as described in this form.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AGREE TO THE TERMS AND CONDITIONS CONTAINED HEREIN. I HEREBY CERTIFY THAT I AM THE PARENT OR LEGAL GUARDIAN OF THE CHILD NAMED HEREIN.

______________________________ ______________________________

Name of Parent/Legal Guardian (Please Print) Name of Student (Please Print)

______________________________ ______________________________

Signature of Parent/Legal Guardian Relationship to Student

Date of Signature:__________________

Mission Health System, Inc.

Consent and Release for Interview, Photograph, Video Recording, and/or Media Postings

For use by: Mission Health System affiliate hospitals, subsidiaries and managed organizations. This form is not intended to authorize the release of medical records and does not replace the "Authorization to Release Medical Records" forms in use at Mission affiliate hospitals, subsidiaries or managed entities.

This form documents your permission for someone to interview, photograph, video record, and/or audio record you or someone for whom you have the legal right to make decisions, including your child. It could be that the local or national news media is interested in doing a story through a newspaper article, radio spot or television feature or it could be that Mission Health System or one of its related entities is interested in preparing a story, a brochure, a presentation, an advertisement or a website posting, including one or more of the Mission websites. Third party media sites such as YouTube, Twitter, or Facebook may also be used.

1. I understand that I can say no to this request to be interviewed, photographed, video recorded and/or audio recorded and that saying no will not affect treatment, the cost of treatment, or benefits at Mission Health System affiliate hospitals, subsidiaries and managed organizations.

2. I understand that my name and/or the name of the person for whom I make decisions (including my child) may be used. I also understand that, depending on the nature of the project, picture/video images, voice recordings and details about diagnosis/treatment/hospitalization of me or the person for whom I make decisions may also be used.

3. I have been told how the interview information, photograph, video recording, and/or audio recording will be used and the purpose of the project.

4. I understand that I will not be paid now or later.

5. I give permission for these materials to be used for any and all legitimate purposes, including educating the public, fundraising, or promoting Mission (including use on Mission's websites and in Mission presentations) and for use by third party media companies.

6. I understand that the interview information, pictures, video recordings and/or voice recordings become(s) the property of the organization that creates and publishes such items and I give up all rights to these materials.

7. I understand that it is impossible to control the use of pictures, video recordings, audio recordings and interview information once these items are made public, and I understand that Mission has no control over what others may do with them. Various postings may occur on internet websites including YouTube, Twitter, Facebook and so forth. These materials may continue to exist and be accessible in some form in the future.

8. By signing below, I give permission for Mission and third party media companies to use this material until I cancel my authorization by giving written notice to Mission Health Information Management (cc: Mission Marketing and Digital Strategies Department), 509 Biltmore Avenue, Asheville, N.C. 28801. I understand that canceling this consent will not affect any action that a Mission entity or a third party has already taken in reliance on this consent before receiving my written notice of cancellation and that cancellation will not ensure deletion of the materials from all places.

9. By signing this consent, I release Mission Health System, Inc., and its affiliated and managed entities from liability from any claims, costs, expenses and damages that might result from the interview information, photographs, video recordings and/or audio recordings being used.

Field	
Project Type	☐Interview ☐Photograph ☐Video/Audio Recording
Today's Date	
Project Description	
Name of Person Being Interviewed, Photographed, and/or Recorded	
Date of Birth	
Gender	☐Male ☐Female
Address	
Telephone Number	
E-mail Address	
Signature of Person Giving Consent	
If Person Being Interviewed, Photographed, and/or Recorded is a Minor, Print the Name of Person Giving Consent Here and Indicate Relationship to the Minor.	
Name of Mission Staff Witnessing Consent	
Signature of Mission Staff Witnessing Consent	
Interviewer's Company	
Photographer/Videographer's Company	
Audio Recorder's Company	

Medication Agent Form

This form must be completed if you authorize the Athletic Trainer to administer prescribed medications to your child as needed for conditions such as allergies (epi pen), diabetes (insulin), or asthma (inhaler).

I, ____, the parent/legal guardian of

____,a student at_________________

(the "School") whose date of birth is _____________, authorize Mission Health System, Inc. and each of its affiliated, participating hospitals as applicable including Mission Hospital, Inc., Blue Ridge Regional Hospital, Inc., Mission Hospital McDowell, Inc., Angel Medical Center, Inc., Highlands-Cashiers Hospital, Inc. and Transylvania Community Hospital, Inc. (collectively and/or individually as is applicable referred to herein as "Mission") and their respective staff , as applicable, under the supervision and protocol of a physician, to receive, store, and administer indicated medication, which is prescribed in my child's name.

The medication is:____

I authorize the release of any information pertaining to my listed medications to Mission.
Printed Athlete's Name: ___________________________ **DOB:** ____________

Medication(s) Prescribed:____

Prescribing Physician Name, Address, and Phone Number:

____

Condition requiring Prescription: _____________________________________

Dosage and Administration Instructions: ___________________________________

____

____

_______________________________ _______________________________

Name of Parent/Legal Guardian (please print) Relationship to Student

____

Signature of Parent/Legal Guardian Date

Highlands School Athletic Eligibility & Authorization
2018-2019

Athlete's Name ____ **Date of Birth:** ____________________

Age: ________ **Grade:**________ **Physical Date:** ________________ **GW Concussion Statement:** ____________________

Parent/Guardian Name: ______________________________ **Signature:** ______________________________

Phone:________________________ **Email:** ____

Physical Address: ____

I have read and reviewed the general requirements for high school athletic eligibility and I have discussed these requirements with my student-athlete. I understand that any questions or specific circumstances should be directed to my student's principal, athletic director, or coach.

I certify that the home address as parents shown above is my sole bona fide residence, and I will notify the school principal immediately of any change in residence, since such a change in residence may alter the eligibility status of my student-athlete. I further acknowledge I must not falsify any official eligibility information such as residency/address. Penalty for such an act of falsification will result in loss of eligibility for 365 days. I certify that all other information contained on this form is accurate and current.

I acknowledge that there is a risk of injury with athletic participation. Even with the best coaching, use of the most advanced protective equipment, and strict observance of the rules, injuries are still a possibility, and, on rare occasions, these injuries can be so severe as to result in total disability, paralysis, or even death. I also acknowledge that it is impossible to eliminate these risks.

In accordance with the rules of the NCHSAA, I hereby give my consent for the participation of my student-athlete in the following activities that are circled below:

Basketball	Golf	Volleyball	Cheerleading	Soccer	Cross Country	Football
Indoor Track	Tennis	Softball	Wrestling	Baseball	Outdoor Track	Swimming

In recognizing that there are inherent risks in all athletic events (head and spinal injuries, fractures, etc.), I hereby give my permission to Highlands School for my son/daughter to participate in interscholastic athletic activities.

Permission is hereby granted to Highlands School and its authorized representatives to proceed with any needed medical or minor surgical treatment, x-ray examination, and immunizations for the above named individual in my absence. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that all attempts will be made by the attending physician to contact me in the utmost expeditious manner possible. If said physician is unable to communicate with me, the treatment necessary for the best interest of the above named individual may be given.

I hereby release Highlands School and members of its athletic staff, including but not limited to its coaches, trainers, administrators, and all others connected with school athletic activities, and any attending physicians or surgeons, from any and all damages for injuries sustained by my son/daughter while participating in Highlands School athletic events.

Please check the appropriate response:

_____ My son/daughter has school insurance. _____ My son/daughter is covered by accident insurance through a private policy.

Full name of insurance co. ______________________ Policy # ____________________ Group #______________

_____ My son/daughter is not covered by accident insurance. **(I realize that the lack of insurance may be cause for my child to be denied participation in interscholastic athletic competition.)**

_____ I want to purchase school insurance for my son/daughter.

Is the above named student allergic to any medication? _____ Yes _____ No If yes, list medications ____________________

Emergency Contact : ____

CONSENT TO URINE TESTING

AUTHORIZATION OF RELEASE OF INFORMATION

My parents and I hereby consent to have samples of my urine collected during the 2017-2018 school year, to be tested for the presence of certain drugs and substances in accordance with the provisions of the Highlands School Drug Screening Policy for Athletes.

We further authorize the confidential release of all information and records, including test results, that you may have relating to the screening or testing of my urine samples to school administrative officials, the Athletic Director, the coaches of any interscholastic sport in which I participate, and the drug counseling program used by Highlands School Drug Screening Policy. To the extent set forth in this document, I waive any privilege I may have in connection with suchinformation.

We understand that urine samples will be tested by a certified laboratory designated by Highlands School.

The Macon County Board of Education and its officers, administrators, employees and agents are hereby released from legal responsibility or liability for the release of such information and records as authorized by this form.

STUDENT ATHLETE PLEDGE

As a student athlete, I know I am a role model. I understand the spirit of fair play while playing hard. I will refrain from engaging in all types of disrespectful behavior, including inappropriate language, taunting, trash talking, and unnecessary physical contact. I know the behavior expectations of my school, my conference, and the NCHSAA and hereby accept the responsibility and privilege of representing this school and community as a student athlete.

STUDENT ATHLETE' S PARENT PLEDGE

As a parent, I acknowledge that I am a role model. I will remember that school athletics is an extension of the classroom, offering learning experiences for the students. I must show respect for all players, coaches, spectators, and support groups. I will participate in cheers that support, encourage, and uplift the teams involved. I understand the spirit of fair play and the good sportsmanship expected by our school, our conference and the NCHSAA. I hereby accept my responsibility to be a model of good sportsmanship that comes with being the parent of a student athlete.

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

NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION SPORT PREPARTICIPATION EXAMINATION FORM

Student Athlete's Name: ______________________ Age: ________ Sex: ____________

This is a screening examination for participation in sports. <u>This does not substitute for a comprehensive examination</u> with your child's regular physician where important preventive health information can be covered.

<u>Student-Athlete's Directions:</u> Please review all questions with your parent or legal custodian and answer them to the best of your knowledge.
<u>Parent/Legal Custodian Directions:</u> Please assure that all questions are answered to the best of your knowledge. If you do not understand or are unsure about the answer to a question please ask your doctor. Not disclosing accurate information may put your child at risk during sports activity.
<u>Physician's Directions:</u> We recommend carefully reviewing these questions and clarifying any "Yes" or "Unsure" answers.

Explain "Yes" or "Unsure" answers in the space provided below or on an attached separate sheet if needed.	Yes	No	Unsure
1. Does the student-athlete have any chronic medical illnesses [diabetes, asthma (exercise asthma), kidney problems, etc.]? List:	❑	❑	❑
2. Is the student-athlete presently taking any medications or pills?	❑	❑	❑
3. Does the student-athlete have any allergies (medicine, bees or other stinging insects, latex)?	❑	❑	❑
4. Does the student-athlete have the sickle cell trait?	❑	❑	❑
5. Has the student-athlete ever had a head injury, been knocked out, or had a concussion?	❑	❑	❑
6. Has the student-athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?	❑	❑	❑
7. Has the student-athlete ever passed out or nearly passed out DURING exercise, emotion or startle?	❑	❑	❑
8. Has the student-athlete ever fainted or passed out AFTER exercise?	❑	❑	❑
9. Has the student-athlete had extreme fatigue (been really tired) with exercise (different from other children)?	❑	❑	❑
10. Has the student-athlete ever had trouble breathing during exercise, or a cough with exercise?	❑	❑	❑
11. Has the student-athlete ever been diagnosed with exercise-induced asthma?	❑	❑	❑
12. Has a doctor ever told the student-athlete that they have high blood pressure?	❑	❑	❑
13. Has a doctor ever told the student-athlete that they have a heart infection?	❑	❑	❑
14. Has a doctor ever ordered an EKG or other test for the student-athlete's heart, or has the athlete ever been told they have a heart murmur?	❑	❑	❑
15. Has the student-athlete ever had discomfort, pain, or pressure in his chest during or after exercise or complained of their heart "racing" or "skipping beats"?	❑	❑	❑
16. Has the student-athlete ever had a seizure or been diagnosed with an unexplained seizure problem?	❑	❑	❑
17. Has the student-athlete ever had a stinger, burner or pinched nerve?	❑	❑	❑
18. Has the student-athlete ever had any problems with their eyes or vision?	❑	❑	❑
19. Place a check beside each body part that the student-athlete has ever sprained/strained, dislocated, fractured, broken had repeated swelling in or had any other type of injury to any bones or joints? ❑ Head ❑ Shoulder ❑ Thigh ❑ Neck ❑ Elbow ❑ Knee ❑ Chest ❑ Hip ❑ Forearm ❑ Shin/calf ❑ Back ❑ Wrist ❑ Ankle ❑ Hand ❑ Foot Other: ________			
20. Has the student-athlete ever had an eating disorder, or are there concerns about his/her eating habits or weight?	❑	❑	❑
21. Has the student-athlete ever been hospitalized or had surgery?	❑	❑	❑
22. Has the student-athlete had a medical problem or injury since their last evaluation?	❑	❑	❑
23. (Place a check beside each statement that applies to the student-athlete, elaborate in the space provided below). ❑ 1. Has the student-athlete had little interest or pleasure in doing things? ❑ 2. Has the student-athlete been feeling down, depressed, or hopeless for more than 2 weeks in a row? ❑ 3. Has the student-athlete been feeling bad about himself/herself that they are a failure, or let their family down? ❑ 4. Has the student-athlete had thoughts that he/she would be better off dead or hurting themselves?			
FAMILY HISTORY			
24. Has any family member had a sudden, unexpected death before age 50 (including from sudden infant death syndrome [SIDS], car accident, drowning)?	❑	❑	❑
25. Has any family member had unexplained heart attacks, fainting or seizures?	❑	❑	❑
26. Does the athlete have a father, mother or brother with sickle cell disease?	❑	❑	❑

Explain "yes" or "unsure" answers here: ____

By signing below, I agree that I have reviewed and answered each question above. Every question is answered completely and is correct to the best of my knowledge. Furthermore, as parent or legal custodian, I give consent for this examination and give permission for my child to participate in sports.

Signature of parent/legal custodian: ______________________ Date: __________ Phone #: ______________

Signature of Athlete: ______________________ Date: __________

Student-Athlete's Name: ______________________________ **Age:** _____ **Date of Birth:** _______________

Height: ___________ **Weight:** ___________ **BP** _________ (% ile) / _________ (% ile) **Pulse:** ______

Vision: R 20/ _______ **L 20/** _______ **Corrected: Y N**

Physical Examination (Below Must be Completed by Licensed Physician, Nurse Practitioner or Physician Assistant)

These are required elements for all examinations			
	NORMAL	ABNORMAL	ABNORMAL FINDINGS
PULSES			
HEART			
LUNGS			
SKIN			
NECK/BACK			
SHOULDER			
KNEE			
ANKLE/FOOT			
Other Orthopedic Problems			

Optional Examination Elements – Should be done if history indicates			
HEENT			
ABDOMINAL			
GENITALIA (MALES)			
HERNIA (MALES)			

Clearance:

- ☐ A. Cleared
- ☐ B. Cleared after completing evaluation/rehabilitation for: ______________________________
- ☐ *** C. Medical Waiver Form must be attached (for the condition of: ______________________________)
- ☐ D. Not cleared for: ☐ Collision ☐ Contact ☐ Non-contact _____Strenuous_____Moderately strenuous_____Non-strenuous

Due to: ______________________________

____

____

Additional Recommendations/Rehab Instructions: ______________________________

____

____

Name of Physician/Extender: ______________________________ (Please print)

Signature of Physician/Extender: ______________________________ MD DO PA NP (Please circle)

(Both signature and circle of designated degree required)

Date of Examination: ______________________________

Address: ______________________________

____

Phone: ______________________________

Physician Office Stamp

(*** The following are considered disqualifying until appropriate medical and parental releases are obtained: post-operative clearance, acute infections, obvious growth retardation, uncontrolled diabetes, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or Stage 2 hypertension, enlarged liver or spleen, a chronic musculoskeletal condition that limits ability for safe exercise/sport (i.e. Klippel-Feil anomaly, Sprengel's deformity), history of uncontrolled seizures, absence of/ or one kidney, eye, testicle or ovary, etc.)

This form is approved by the North Carolina High School Athletic Association Sports Medicine Advisory Committee and the NCHSAA Board of Directors.

Gfeller-Waller NCHSAA Student-Athlete & Parent/Legal Custodian Concussion Information Sheet

What is a concussion? A concussion is an injury to the brain caused by a direct or indirect blow to the head. It results in your brain not working as it should. It may or may not cause you to black out or pass out. It can happen to you from a fall, a hit to the head, or a hit to the body that causes your head and your brain to move quickly back and forth.

How do I know if I have a concussion? There are many signs and symptoms that you may have following a concussion. A concussion can affect your thinking, the way your body feels, your mood, or your sleep. Here is what to look for:

Thinking/Remembering	Physical	Emotional/Mood	Sleep
Difficulty thinking clearly	Headache	Irritability-things bother you more easily	Sleeping more than usual
Taking longer to figure things out	Fuzzy or blurry vision	Sadness	Sleeping less than usual
Difficulty concentrating	Feeling sick to your stomach/queasy	Being more moody	Trouble falling asleep
Difficulty remembering new information	Vomiting/throwing up	Feeling nervous or worried	Feeling tired
	Dizziness	Crying more	
	Balance problems		
	Sensitivity to noise or light		

Table is adapted from the Centers for Disease Control and Prevention (http://www.cdc.gov/concussion/)

What should I do if I think I have a concussion? If you are having any of the signs or symptoms listed above, you should tell your parents, coach, athletic trainer or school nurse so they can get you the help you need. If a parent notices these symptoms, they should inform the school nurse or athletic trainer.

When should I be particularly concerned? If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, or your words are coming out funny/slurred, you should let an adult like your parent or coach or teacher know right away, so they can get you the help you need before things get any worse.

What are some of the problems that may affect me after a concussion? You may have trouble in some of your classes at school or even with activities at home. If you continue to play or return to play too early with a concussion, you may have long term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur Once you have a concussion, you are more likely to have another concussion.

How do I know when it's ok to return to physical activity and my sport after a concussion? After telling your coach, your parents, and any medical personnel around that you think you have a concussion, you will probably be seen by a doctor trained in helping people with concussions. Your school and your parents can help you decide who is best to treat you and help to make the decision on when you should return to activity/play or practice. Your school will have a policy in place for how to treat concussions. You should not return to play or practice on the same day as your suspected concussion.

You should not have any symptoms at rest or during/after activity when you return to play, as this is a sign your brain has not recovered from the injury.

This information is provided to you by the UNC Matthew Gfeller Sport-Related TBI Research Center, North Carolina Medical Society, North Carolina Athletic Trainers' Association, Brain Injury Association of North Carolina, North Carolina Neuropsychological Society, and North Carolina High School Athletic Association.

Rev May 2016

Approved for use in 2018-19 School Year

Gfeller-Waller NCHSAA Student-Athlete & Parent/Legal Custodian Concussion Statement Form

Instructions: The student athlete and his/her parent or legal custodian, must initial beside each statement acknowledging that they have read and understand the corresponding statement. The student-athlete should initial in the left column and the parent or legal custodian should initial in the right column. Some statements are applicable only to the student-athlete and should only be initialed by the student-athlete. This form must be completed for each student-athlete, even if there are multiple student-athletes in the household.

Student-Athlete Name: (please print)____

Parent/Legal Custodian Name(s): (please print)__________________________________

Student-Athlete Initials		Parent/Legal Custodian(s) Initials
	A concussion is a brain injury, which should be reported to my parent(s) or legal custodian(s), my or my child's coach(es), or a medical professional if one is available.	
	A concussion cannot be "seen." Some signs and symptoms might be present immediately; however, other symptoms can appear hours or days after an injury.	
	I will tell my parents, my coach and/or a medical professional about my injuries and illnesses.	Not Applicable
	If I think a teammate has a concussion, I should tell my coach(es), parent(s)/ legal custodian(s) or medical professional about the concussion.	Not Applicable
	I, or my child, will not return to play in a game or practice if a hit to my, or my child's, head or body causes any concussion-related symptoms.	
	I, or my child, will need written permission from a medical professional trained in concussion management to return to play or practice after a concussion.	
	Based on the latest data, most concussions take days or weeks to get better. A concussion may not go away, right away. I realize that resolution from a concussion is a process that may require more than one medical visit.	
	I realize that ER/Urgent Care physicians will not provide clearance to return to play or practice, if seen immediately or shortly after the injury.	
	After a concussion, the brain needs time to heal. I understand that I or my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before concussion symptoms go away.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I have read the concussion symptoms listed on the Student-Athlete/ Parent Legal Custodian Concussion Information Sheet.	
	I have asked an adult and/or medical professional to explain any information contained in the Student-Athlete & Parent Concussion Statement Form or Information Sheet that I do not understand.	

By signing below, we agree that we have read and understand the information contained in the Student-Athlete & Parent/Legal Custodian Concussion Statement Form, and have initialed appropriately beside each statement.

____________________________ ____________
Signature of Student-Athlete Date

____________________________ ____________
Signature of Parent/Legal Custodian Date

MISSION SPORTS MEDICINE

SUDDEN CARDIAC DEATH IN YOUNG ATHLETES
INFORMATION FOR STUDENT-ATHLETES AND PARENTS/LEGAL CUSTODIANS

What is sudden cardiac death in the young athlete?
Sudden cardiac death is the result of an unexpected failure of proper heart function, usually during or immediately after exercise without trauma. Since the heart stops pumping adequately, the athlete quickly collapses, loses consciousness, and ultimately dies unless normal heart rhythm is restored using an automatic external defibrillator (AED).

How common is sudden death in young athletes?
Rare. About 100 such deaths are reported in the US per year. The chance of death occurring to any individual high school athlete is about 1 in 200,000/year. Sudden cardiac death is more common in males than females; in football and basketball than in other sports; and in African Americans than in other races and ethnic groups.

What are the most common causes?
Research suggests that the main cause of is a loss of proper heart rhythm, causing the heart to quiver in-stead of pumping blood to the brain and the body. This is called ventricular fibrillation and is caused by one of several cardiovascular abnormalities and electrical diseases of the heart that may go unnoticed in healthy appearing athletes. The most common cause is hyper-trophic cardiomyopathy, which is a disease of the heart with abnormal thickening of the heart muscle which can cause rhythm problems and blockages to blood flow. This is a genetic disease that may run in families and gradually develop over many years. The second most common cause is congenital abnormalities of the coronary arteries in which the blood vessels supplying the heart are formed abnormally. Other causes include myocarditis (inflammation of the heart, usually due to a virus), dilated cardiomyopathy (enlargement of the heart, often for unknown reasons), long QT syndrome and other electrical abnormalities of the heart, and Marfan syndrome (an inherited disorder involving abnormalities of the heart valves and major arteries, often seen in unusually tall athletes).

Are there warning signs to watch for?
Yes, in more than 1/3 of these sudden cardiac deaths, there were warning signs that were not reported or taken seriously. These include:

- History of a heart murmur
- Chest pains, at rest or during exertion
- Fatigue or tiring more quickly than peers
- Dizziness or lightheadedness, especially during exertion
- Fainting, seizure, or convulsions during physical activity
- Being unable to keep up with friends due to shortness of breath (labored breathing)
- Fainting or seizures during emotional excitement, emotional distress, or being startled
- Palpitations—awareness of the heart beating unusually (skipping, irregular, or extra beats) during athletics or cool down periods after athletic participation
- Family history of sudden death during physical activity or during a seizure
- Family history of sudden, unexpected death before age 50
- Family history of cardiac or aortic disease under 50 years of age

When should a student athlete see a heart specialist?
If the primary care provider or school physician has concerns, referral to a pediatric cardiologist is recommended. This specialist will perform a more thorough evaluation, including an electrocardiogram (ECG), which is a graph of the electrical activity of the heart. An echocardiogram (ECHO), which is an ultrasound of the heart to allow for direct visualization of the heart structure may also be done. Other possible tests include a treadmill exercise test and monitor to enable longer re-cording of heart rhythm. None of the testing is invasive or uncomfortable.

Can sudden cardiac death be prevented through proper screening?
A proper evaluation should find most, but not all, conditions that would cause sudden death in the athlete. That is because some diseases are difficult to uncover and may only develop later in life. Others can develop following a normal screening evaluation, such as an infection of the heart muscle from a virus. That is why screening evaluations and a review of the family health history need to be performed on a yearly basis. With proper screening and evaluation, most cases can be identified and prevented.

Student – Athlete & Parent/Legal Custodian Sudden Cardiac Death in Young Athlete Statement

**If there is anything on this sheet that you do not understand, please ask an adult to explain or read it to you.*

Student-Athlete Name: ____

(This form must be completed for each student-athlete, even if there are multiple student-athletes in each household)

Parent/Legal Custodian Name(s): ____________________________________

☐ We have read the *Student-athlete and Parent/Legal Custodian Sudden Cardiac Death in Young Athlete Information Sheet*. If true, please check box.

After reading the information sheet I am aware of the following information:

Student-athlete initials		Parent/Legal Custodian Initials
	Chest pain with exercise should be reported to my parents, my coaches, or a medical professional if one is available.	
	Dizziness, lightheadedness, or fainting with exercise or just after exercise should be reported to my parents, my coaches, or a medical professional if one is available.	
	Palpitations (skipping, irregular, or extra beats) during athletics or cool down periods after athletic participation should be reported to my parents, my coaches, or a medical professional if one is available.	
	A history of a murmur or other known cardiac abnormalities should be reported as part of the pre-participation sports physical.	
	A family history of sudden, unexpected death before age 50 or inheritable cardiac disease should be should be reported as part of the pre-participation sports physical.	
	I will/my child will need written permission to participate in athletics from a medical professional should warning signs be noted or abnormalities be noted on pre-participation sports physical.	
	I realize that further testing for cardiac disease may be necessary if warning signs are noted or abnormalities are noted on pre-participation sports physical.	

____

Signature of Student – Athlete Date

____

Signature of Parent/Legal Guardian Date