

# PHYSICAL EXAMINATION INSTRUCTIONS

## I. Requirement of School Boards.

- A. Each governing board shall decide if the exam is to be repeated on an annual basis, on a biennial basis or triennial basis.
- B. Each governing board shall decide whether they want the doctors to evaluate sexual maturity based upon the Tanner Maturation Index. Please white-out item 13 on the Physical Exam form if the decision is NOT to use the Tanner Maturation Index.

## II. Requirements of Member Schools.

- A. Each member school shall make copies of the forms that must be completed by the parents and/or doctors in sufficient quantities to meet your needs.
- B. Member schools must keep on file the following:
  1. A copy of the **PARENT PERMIT FORM**. This form must be submitted annually.
  2. A copy of the **INITIAL PRE-PARTICIPATION HISTORY** report for each student who takes the comprehensive exam for the first time. This form must be made available to the medical examiner at the time the student takes his/her first physical exam.
  3. A copy of the **INTERIM PRE-PARTICIPATION HISTORY** for each student must be submitted annually by the parents except on the very first occasion when the **INITIAL PRE-PARTICIPATION HISTORY** is required.

All questions on the **INTERIM PRE-PARTICIPATION HISTORY** form should be answered with the following in mind: **IN THE PAST YEAR:** Please explain any yes answers in the space provided on the form. Any yes answers may require a re-visit to the medical provider for re-certification of health. The parent/guardian signature denotes that the student is physically able to participate.
  4. A copy of the comprehensive **PHYSICAL EXAMINATION** signed by either a Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, Physician Assistant or Nurse Practitioner.
- C. Member schools may commence scheduling physical exams as early as April 1 for the ensuing school year.

## III. Role of Doctors, Physician Assistant and Nurse Practitioners.

- A. The certification/signing of the physical exam form is reserved for only a Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, a Physician Assistant or Nurse Practitioner. Stamping the name of a medical clinic or a medical association as a substitute for the authorized signature is unacceptable. All exams must be signed by authorized medical personnel as listed in paragraph two above.
- B. The examiner shall receive a copy of Instructions for conducting the orthopedic screening and other portions of the exam. The instruction sheet follows the other forms located in this section of this publication.
- C. The medical history form must be made available to the person(s) conducting the physical exam at the time the examination takes place.

# SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION

## PHYSICAL EXAMINATION ITEMS TO BE EVALUATED

### Station 1 - Individual History

All YES items in the history are reviewed in detail to determine if they constitute a risk to participation by the athlete, or need additional evaluation.

### Station 2 - Blood Pressure

Right arm, sitting. Values needing recheck and possible further evaluation are:

Under 11 Years 130/75  
12 years and older 140/85

### Station 3 - Vision (Snellen)

Uncorrected vision less than 20/200, corrected vision less than 20/40 requires further evaluation.

### Station 4 - Skin, Mouth, Eyes, Ears

Pustular acne, herpes or other infections, athlete's foot; braces, dental prostheses, severe caries, pupil inequality, contacts; ear drainage, malformation.

### Station 5 - Chest

Review of cardiac-related history. Heart enlargement, pulse discrepancy, murmurs, abnormal rhythm, forced expiratory maneuver, evidence of latent bronchospasm.

### Station 6 - Lymphatics, Abdomen, Genitalia

Cervical or axillary adenopathy, organomegaly, absence of testicles, and hernia (males only).

### Station 7 - Orthopedic

Asymmetry, scoliosis, swelling or deformity, decreased range of motion or strength

### Station 8 - Review

#### CLEARANCE

- Cleared for ALL (*collision, contact/endurance sports, and other sports*)
- Cleared only for *contact/endurance sports* and *other sports*
- Cleared only for *other sports*

**Definition:** [Collision=Football and Wrestling]; [Contact/Endurance Sports=Basketball, Cross Country, Gymnastics, Soccer, Tennis, Track, Volleyball, Competitive Cheer and Competitive Dance]; [Other Sports=Golf]

- Cleared for ALL, but with recommendations for further evaluation or treatment for \_\_\_\_\_
- Above clearance to be granted only after \_\_\_\_\_
- Clearance cannot be given at this time because \_\_\_\_\_

**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION  
ORTHOPEDIC SCREENING GUIDE**

<b>Athletic Activity (Instructions)</b>	<b>Observation</b>
Stand Facing Examiner	General habitus; acromioclavicular joints
Look at ceiling, floor, over both shoulders; touch ears to shoulders	Cervical spine motion
Shrug shoulders (examiner resists)	Trapezius strength
Abduct shoulder 90 degrees (examiner resists at 90 degrees)	Deltoid strength
Full external rotation of arms	Shoulder motion
Flex and extend elbows	Elbow motion
Arms at sides, elbow 90 degrees flexed, pronate and supinate wrists	Elbow and wrist motion
Spread fingers; make fist	Hand or finger motion and deformities
Tighten (contact) quadriceps; relax quadriceps	Symmetry and knee effusion; ankle effusion
"Duck walk" four steps (away from the examiner with buttocks on heels)	Hip, knee and ankle motion
Back to examiner; knees straight, touch toes	Shoulder symmetry; scoliosis, hip motion, hamstring tightness
Raise up on toes, raise heels	Calf symmetry, leg strength

**May require reflex hammer, tape measure, pin, and examination table.**

**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION  
ANNUAL PARENT OR GUARDIAN PERMIT**

I hereby give my consent for \_\_\_\_\_ GRADE \_\_\_\_\_  
Name (Please Print) 2018-19 School Year

who was born at \_\_\_\_\_  
City, Town, County, State

on \_\_\_\_\_ to compete in SDHSAA approved athletics for \_\_\_\_\_ High School  
Date of Birth

during the 2018-19 school year.

I/We give our permission for our son/daughter to participate in organized high school athletics, realizing that such activity involves the potential for injury which is inherent in all sports.

Date \_\_\_\_\_, 20\_\_\_\_ Signed \_\_\_\_\_  
Parent or Legal Guardian

**THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL.**

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**INITIAL PRE-PARTICIPATION HISTORY**

**SEE REVERSE SIDE FOR**

**HEALTH HISTORY QUESTIONNAIRE**

# PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

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

Date of Exam \_\_\_\_\_  
 Name \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Do you have any allergies?  Yes  No If yes, please identify specific allergy below.

Medicines  Pollens  Food  Stinging Insects

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

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

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

Explain "yes" answers here

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

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**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION  
ANNUAL PARENT OR GUARDIAN PERMIT**

I hereby give my consent for \_\_\_\_\_ GRADE \_\_\_\_\_  
Name (Please Print) 2018-19 SCHOOL YEAR  
who was born at \_\_\_\_\_ on \_\_\_\_\_  
City, Town, County, State Date of Birth  
to compete in SDHSAA approved athletics for \_\_\_\_\_ High School during the 2018-19 school year.

I/We give our permission for our son/daughter to participate in organized high school athletics, realizing that such activity involves the potential for injury which is inherent in all sports.

Signed \_\_\_\_\_ Date \_\_\_\_\_, 20\_\_\_\_  
Parent or Legal Guardian

**THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL.**

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**INTERIM PRE-PARTICIPATION HISTORY**  
(Used in conjunction with the Biennial/Triennial examination.)

**SEE REVERSE SIDE FOR  
HEALTH HISTORY QUESTIONNAIRE**

# INTERIM PRE-PARTICIPATION HISTORY

(Used in conjunction with the Biennial/Triennial examination.)

NAME \_\_\_\_\_ GRADE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
 (2018-19 School Year)

## IN THE PAST YEAR:

		YES	NO
1.	Has a doctor denied your participation in sports for any reason?		
2.	Do you have a new ongoing medical condition (like diabetes or asthma)?		
3.	Are you currently taking any new prescription or non-prescription (over-the-counter) medicines or pills?		
4.	Do you have new allergies to medicines, pollens, foods, or stinging insects?		
5.	Have you passed out or nearly passed out DURING exercise?		
6.	Have you passed out or nearly passed out AFTER exercise?		
7.	Have you had discomfort, pain, or pressure in your chest during exercise?		
8.	Has your heart raced or skipped beats during exercise?		
9.	Has a doctor told you that you have a heart murmur, high blood pressure, high cholesterol, or a heart infection?		
10.	Has a doctor ordered a test for your heart? (for example: ECG, echocardiogram)		
11.	Has anyone in your family died for no apparent reason?		
12.	Have you spent the night in a hospital?		
13.	Have you had surgery?		
14.	Have you had an injury, like a sprain, muscle or ligament tear, or tendonitis, that required medical attention?		
15.	Have you had any broken or fractured bones or dislocated joints?		
16.	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?		

		YES	NO
17.	Have you had a stress fracture?		
18.	Did a doctor tell you that you have asthma or allergies?		
19.	Have you started to cough, wheeze, or have difficulty breathing during or after exercise?		
20.	Have you used an inhaler or taken asthma medicine?		
21.	Have you lost a kidney, an eye, a testicle, or any other organ?		
22.	Do you have any new rashes, pressure sores, or other skin problems?		
23.	Have you had a new herpes skin infection?		
24.	Have you had a head injury or concussion?		
25.	Have you been hit in the head and been confused or lost your memory?		
26.	Have you had a seizure?		
27.	Have you experienced headaches with exercise?		
28.	Have you had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
29.	Have you been unable to move your arms or legs after being hit or falling?		
30.	When exercising in the heat, did you have severe muscle cramps or become ill?		

Explain "Yes" answers here: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(continue on front side of this form if necessary)

## RECERTIFICATION OF HEALTH

As the parent/guardian, I herewith affix my signature and certify that the above-named student is physically fit to participate in interscholastic athletics for the current school year insofar as all "Yes" responses are concerned.

\_\_\_\_\_, 20\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Parent



This is the form that the South Dakota High School Activities Association recommends to those member schools that feel it is important to get consent from parents and/or legal guardians for medical treatment when away from home on road trips for various activities. This form should be kept on file at the school and another copy should travel with each team on which the athlete competes.

## CONSENT FOR MEDICAL TREATMENT

I am the **PLEASE CIRCLE ONE** Mother Father Legal Guardian of \_\_\_\_\_  
\_\_\_\_\_, who participates in co-curricular activities for \_\_\_\_\_  
\_\_\_\_\_ High School. I hereby consent to any medical services that may be required while said child is under the supervision of an employee of the \_\_\_\_\_ School District while on a school-sponsored activity and hereby appoint said employee to act on behalf in securing necessary medical services from any duly licensed medical provider.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Parent(s)/Legal Guardian Signature: \_\_\_\_\_

## CONSENT OF CHILD

I, \_\_\_\_\_, have read the above Consent For Medical Treatment Form signed by my (**PLEASE CIRCLE ONE**) Mother Father Legal Guardian and join with (**PLEASE CIRCLE ONE**) him her in the consent.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Student's Signature: \_\_\_\_\_



**CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM (HIPAA)**

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. I authorize the use or disclosure of the above-named individual's health information including the Initial and Interim Pre-Participation History and Physical Exam information pertaining to a student's ability to participate in South Dakota High School Activities Association sponsored activities. Such disclosure may be made by any Health Care Provider generating or maintaining such information.
2. The information identified above may be used by or disclosed to the school nurse, athletic trainer, coaches, medical providers and other school personnel involved in the care of this student.
3. This information for which I am authorizing disclosure will be used for the purpose of determining the student's eligibility to participate in extracurricular activities, any limitations on such participation and any treatment needs of the student.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the school administration. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. This authorization will expire on July 1, 2019.
6. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
7. I understand authorizing the use or disclosure of the information identified above is voluntary. However, a student's eligibility to participate in extracurricular activities depends on such authorization. I need not sign this form to ensure healthcare treatment.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Student (If Over 18)

\_\_\_\_\_  
Date

**This form must be completed annually and must be available for inspection at the school**

## RETURN TO COMPETITION, PRACTICE, OR TRAINING

This form is to be used after a youth athlete is removed from, and not returned to, competition, practice, or training after exhibiting concussion symptoms. The youth athlete should not be returned to competition, practice, or training until written authorization is obtained from an appropriate health care professional and the parent/guardians. A licensed health care provider is a person who is:

- (1) Registered, certified, licensed, or otherwise recognized in law by the State of South Dakota to provide medical treatment; and
- (2) Trained and experienced in the evaluation, management, and care of concussions.

This form should be kept on file at the school and need not be forwarded to the SDHSAA Office.

Athlete: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Sport: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

### REASON FOR ATHLETE'S INCAPACITY

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### Guidelines for returning to competition, practice, or training after a concussion

Note: Each step should be completed with no concussion symptoms before proceeding to the next step.

1. No activity, complete rest with no symptoms.
2. Light exercises: walking or stationary cycling with no symptoms.
3. Sport specific activity without body contact and no symptoms.
4. Practice without body contact and no symptoms. Resume resistance training.
5. Practice with body contact and no symptoms.
6. Return to game play with no symptoms.

Note:

1. If symptoms return at any time during the rehabilitation process, wait until asymptomatic for 1 full day, then re-start at the previous step.
2. Never return to competition with symptoms.
3. Do not use "smelling salts".
4. **When in doubt, sit them out.**

### HEALTH CARE PROFESSIONAL'S ACTION

I have examined the named student-athlete following this episode and determined the following:

\_\_\_\_\_ **Permission is granted** for the athlete to return to competition, practice, or training

\_\_\_\_\_ **Permission is not granted** for the athlete to return to competition, practice, or training

COMMENT: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_  
Health Care Professional

\_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_ Date: \_\_\_\_\_  
School Administrator

# CONCUSSION FACT SHEET FOR ATHLETES

## *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 your brain normally works
- Can occur during practices or games in any sport or recreational activity
- Can happen even if you haven't been knocked out
- Can be serious even if you've just been "dinged" or "had your bell rung"

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

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

You can't see a concussion, but you might notice one or more of the symptoms listed below or that you "don'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 I do if I think I have a concussion?*

- **Tell your coaches and your parents.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach right away if you think you have a concussion or if one of your teammates might have a concussion.
- **Get a medical check-up.** A doctor or other health care professional can tell if you have a concussion and when it is OK to return to play.
- **Give yourself time to get better.** If you have a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have another concussion. Repeat concussions can increase the time it takes for you to recover and may cause more damage to your brain. It is important to rest and not return to play until you get the OK from your health care professional that you are symptom-free.

## *How can I prevent a concussion?*

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

- Use the proper sports equipment, including personal protective equipment. In order for equipment to protect you, it must be:
  - The right equipment for the game, position, or activity
  - Worn correctly and the correct size and fit
  - Used every time you play or practice
- Follow your coach's rules for safety and the rules of the sport
- Practice good sportsmanship at all times

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

Student's Name (please print) \_\_\_\_\_ Date: \_\_\_\_\_

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

**THIS FORM MUST BE SIGNED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL**

## CONCUSSION FACT SHEET FOR PARENTS

### *What is a concussion?*

A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even or what seems to be a mild bump or blow to the head can be serious.

### *What are the signs and symptoms?*

You can't see a concussion, Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports, one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

Signs Observed By Parents or Guardians	Symptoms Reported by Athlete
<ul style="list-style-type: none"><li>• Appears dazed or stunned</li><li>• Is confused about assignment or position</li><li>• Forgets an instruction</li><li>• Is unsure of game, score, or opponent</li><li>• Moves clumsily</li><li>• Answers questions slowly</li><li>• Loses consciousness (even briefly)</li><li>• Shows mood, behavior, or personality changes</li><li>• Can't recall events prior to hit or fall</li><li>• Can't recall events after hit or fall</li></ul>	<ul style="list-style-type: none"><li>• Headache or "pressure" in head</li><li>• Nausea or vomiting</li><li>• Balance problems or dizziness</li><li>• Double or blurry vision</li><li>• Sensitivity to light or noise</li><li>• Feeling sluggish, hazy, foggy, or groggy</li><li>• Concentration or memory problems</li><li>• Confusion</li><li>• Just not "feeling right" or is "feeling down"</li></ul>

### *How can you help your teen prevent a concussion?*

Every sport is different, but there are steps your teens can take to protect themselves from concussion and other injuries.

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport
- Encourage them to practice good sportsmanship at all times.

### *What should you do if you think your teen has a concussion?*

1. **Keep your teen out of play.** If your teen has a concussion, her/his brain needs time to heal. Don't let your teen return to play the day of the injury and until a health care professional, experienced in evaluating for concussion, says your teen is symptom-free and it's OK to return to play. A repeat concussion that occurs before the brain recovers from the first – usually within a short period of time (hours, days, or weeks) – can slow recovery or increase the likelihood of having long-term problems. In rare cases, repeat concussions can result in edema (brain swelling), permanent brain damage, and even death.
2. **Seek medical attention right away.** A health care professional experienced in evaluating for concussion will be able to decide how serious the concussion is and when it is safe for your teen to return to sports.
3. **Teach your teen that it's not smart to play with a concussion.** Rest is key after a concussion. Sometimes athletes wrongly believe that it shows strength and courage to play injured. Discourage others from pressuring injured athletes to play. Don't let your teen convince you that s/he's "just fine".
4. **Tell all of your teen's coaches and the student's school nurse about ANY concussion.** Coaches, school nurses, and other school staff should know if your teen has ever had a concussion. Your teen may need to limit activities while s/he is recovering from a concussion. Things such as studying, driving, working on a computer, playing video games, or exercising may cause concussion symptoms to reappear or get worse. Talk to your health care professional, as well as your teen's coaches, school nurse, and teachers. If needed, they can help adjust your teen's school activities during her/his recovery.

Parent/Guardian's Name (Please print) \_\_\_\_\_ Date \_\_\_\_\_, 20\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_, 20\_\_\_\_

**THIS FORM MUST BE SIGNED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL**