

### 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

Revised: July 26, 2012

**SECTION 4: UNDERSTANDING OF SUDDEN CARDIAC ARREST 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 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year.

**Are there warning signs?**

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

- dizziness
- lightheadedness
- shortness of breath
- difficulty breathing
- racing or fluttering heartbeat (palpitations)
- syncope (fainting)
- fatigue (extreme tiredness)
- weakness
- nausea
- vomiting
- chest pains

These symptoms can be unclear and confusing in athletes. Often, people confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

**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. When the heart stops, 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 have SCA die from it.

**Act 59 – the Sudden Cardiac Arrest Prevention Act (the Act)**

The Act is intended to keep student-athletes safe while practicing or playing. The requirements of the Act are:

*Information about SCA symptoms and warning signs.*

- Every student-athlete and their parent or guardian must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.
- Schools may *also* hold informational meetings. The meetings can occur before each athletic season. Meetings may include student-athletes, parents, coaches and school officials. Schools may also want to include doctors, nurses, and athletic trainers.

*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 and understand the symptoms and warning signs of SCA.

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.

- |   |                          |  |           |       |           |                  |               |
|---|--------------------------|--|-----------|-------|-----------|------------------|---------------|
|   | Yes                      | No                                       |           |       |           |                  |               |
| 1. Has a doctor ever denied or restricted your participation in sport(s) for any reason?  | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| 2. Do you have an ongoing medical condition (like asthma or diabetes)?  | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?  | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects?   | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| 5. Have you ever passed out or nearly passed out DURING exercise?   | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| 6. Have you ever passed out or nearly passed out AFTER exercise?  | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise?   | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| 8. Does your heart race or skip beats during exercise?  | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| 9. Has a doctor ever told you that you have (check all that apply):   |                          |  |           |       |           |                  |               |
| <input type="checkbox"/> High blood pressure  |                          | <input type="checkbox"/> Heart murmur    |           |       |           |                  |               |
| <input type="checkbox"/> High cholesterol   |                          | <input type="checkbox"/> Heart infection |           |       |           |                  |               |
| 10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)  | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| 11. Has anyone in your family died for no apparent reason?  | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| 12. Does anyone in your family have a heart problem?  | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| 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"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| 14. Does anyone in your family have Marfan syndrome?  | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| 15. Have you ever spent the night in a hospital?  | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| 16. Have you ever had surgery?  | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| 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, circle affected area below:      | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:  | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| 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, circle below: | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| Head  | Neck                     | Shoulder                                 | Upper arm | Elbow | Forearm   | Hand/<br>Fingers | Chest         |
| Upper back  | Lower back               | Hip                                      | Thigh     | Knee  | Calf/shin | Ankle            | Foot/<br>Toes |
| 20. Have you ever had a stress fracture?  | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?  | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |
| 22. Do you regularly use a brace or assistive device?   | <input type="checkbox"/> | <input type="checkbox"/>                 |           |       |           |                  |               |

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | Yes                      | No                       |
| 23. Has a doctor ever told you that you have asthma or allergies?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Is there anyone in your family who has asthma?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever used an inhaler or taken asthma medicine?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?             | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you had infectious mononucleosis (mono) within the last month?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have any rashes, pressure sores, or other skin problems?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you ever had a herpes skin infection?   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>CONCUSSION OR TRAUMATIC BRAIN INJURY</b>  |                          |                          |
| 31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?            | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you been hit in the head and been confused or lost your memory?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Do you experience dizziness and/or headaches with exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?     | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you ever been unable to move your arms or legs after being hit or falling?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. When exercising in the heat, do you have severe muscle cramps or become ill?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Have you had any problems with your eyes or vision?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you wear glasses or contact lenses?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Do you wear protective eyewear, such as goggles or a face shield?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Are you unhappy with your weight?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Are you trying to gain or lose weight?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Has anyone recommended you change your weight or eating habits?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Do you limit or carefully control what you eat?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Do you have any concerns that you would like to discuss with a doctor?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>FEMALES ONLY</b>  |                          |                          |
| 47. Have you ever had a menstrual period?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. How old were you when you had your first menstrual period?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 49. How many periods have you had in the last 12 months?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 50. Are you pregnant?  | <input type="checkbox"/> | <input type="checkbox"/> |

#'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: 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 (circle 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, or SNP (circle one) Authorized Date of CIPPE \_\_\_\_/\_\_\_\_/\_\_\_\_

## KEN LANTZY ATHLETIC INJURY PROTOCOL FOR RETURN TO PLAY

Any participants of Ken Lantzy **MUST** report all injuries to the **Certified Athletic Trainer (ATC)** on site and/or Coach if it is not during scheduled practice times. The participants **ARE NOT PERMITTED** to leave campus and seek evaluation unless approved by the ATC or in the event of a medical emergency during dormitory hours.

- The ATC will evaluate the injury and determine plan of care for the participant's injury.
- Any participant in Ken Lantzy game/practices who suffers an injury and is FURTHER evaluated by MD, DO, PT, DMD, Chiropractor will require a written release to return to athletic participation.
- This release may include any specialist with the credentials MD or DO, Dentist (DMD), PT, Podiatrist, or Chiropractor.

## KEN LANTZY CONCUSSION MANAGEMENT PROTOCOL FOR RETURN TO PLAY

- Any athlete suspected of having signs and symptoms of a head injury during athletic practices and/or games are to be directed for further evaluation by proper medical person who is trained in management of head injuries/concussions (in accordance with State Senate Bill 22, Safety in Youth Sports Act).
- The Certified Athletic Trainer will evaluate and refer the athlete for further medical evaluation if necessary.
- If the athlete is symptomatic for head injury, the parent/guardian will be contacted and practices/competition participation will be determined according to each individual injury until symptoms reside. **This is recommended so that the athlete can rest their brain and also to prevent further injury.**

### STEP-WISE return –to- play:

1. **NO activity –rest until asymptomatic (for 24 hours)**
2. **Light aerobic exercise (asymptomatic 24 hours)**
3. **Sport Specific training (asymptomatic for 24 hours)**
4. **Non-contact Drills (asymptomatic for 24 hours)**
5. **Full contact Drills (MUST HAVE PHYSICIAN CLEARANCE)**
6. **Game play (MUST HAVE PHYSICIAN CLEARANCE) (If symptoms return during any step of return-to-play protocol, begin at step one again once symptom free for 24 hours.)**

### The athlete may return to play only when the following criteria have been met:

1. Symptom free and symptom free upon exertion (STEP-WISE return-to-play protocol).
2. An MD or DO (which may not be a Med Express, I-Care or Med Well doctor) must fill out a RETURN TO PLAY FORM for the athlete **specifically stating that they are current in managing head injuries/concussion management and the athlete has successfully met all criteria listed above without any returning symptoms.**

Parent Signature: \_\_\_\_\_

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

Athlete Signature: \_\_\_\_\_

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