High School / Middle School Sports
Athletic Participation 2017-18

Welcome to the MVCA Family. Thank you for your interest and participation in athletics at Miami Valley Christian Academy. We are committed to “Preparing the Hearts and Minds of our Student-Athletes to Impact the World for Christ!”

OUR GOALS
• To afford participants the opportunity to learn lifelong lessons through participating in sports.
• To instill a winning attitude with diligent preparation and an aggressive pursuit of excellence.
• To model Christ-like attitudes, character, and behavior on and off the field of play.
• To Prepare the Hearts and Minds of our Student-Athletes to Impact the World for Christ.

This packet contains all of the documents that you need to print, complete, sign, and turn-in for your student-athlete to participate. FORMS and FEES must be turned in before student-athlete can participate in any practices or games. Those forms are included in the checklist below:

- 2017-18 Release for Athletic Participation Form (Signed by BOTH Student-Athlete AND Parent)
- 2017-18 Transportation Permission Form (Signed by Parent Only)
- 2017-18 Pre-Participation Physical Form-6 Pages
  - Pages 1, 2, 5, and 6 filled out and signed by BOTH Student-Athlete AND Parent
  - Pages 3 and 4 filled out and signed by Physician
- 2017-18 Concussion Information Form (Signed by BOTH Student-Athlete AND Parent)
- 2017-18 Sudden Cardiac Arrest & Lindsay’s Law Form (Signed by BOTH Student-Athlete AND Parent)
- 2017-18 Authorization to Release Information Form (Signed by BOTH Student-Athlete AND Parent)
- Please be sure to include a check for the Sport Participation Fee
  - THE OFFICE WILL NO LONGER ACCEPT FORMS WITHOUT THE ACCOMPANIED FEES.

The 2017-18 Sports Participation Fees for High School and Middle School Football are –
• MVCA Student = $190
• Non-MVCA Student-Athletes = $250
• Part-Time MVCA Student-Athletes = Sports Fee is part of tuition fee.

The 2017-18 Sports Participation Fees (for all High School and Middle School Sports EXCEPT football) are as follows –
• Student-Athletes 1st Sport of the School Year = $140
• Student-Athletes 2nd Sport of the School Year = $100
• Student-Athletes 3rd Sport of the School Year = No Fee

The forms and fee can be turned in to the Main Entrance of MVCA during regular school hours or mailed to the address below.

Again, we are excited to have you and your child as part of our athletic program and we look forward to seeing how we can glorify God through the program.

Robert Vilardo
MVCA Athletic Director
rvilardo@mvca-oh.com
6830 School Street
Cincinnati, OH 45244
513-272-6822 ext 15

www.mvca-oh.com
www.TheAcademyFootball.com
MIAMI VALLEY CHRISTIAN ACADEMY
RELEASE FOR ATHLETIC PARTICIPATION FORM
2017-18

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>M F</th>
<th>Grade 17-18</th>
<th>Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>Zip</td>
<td>Student Cell #</td>
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<table>
<thead>
<tr>
<th>Parent/Guardian #1</th>
<th>Email</th>
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<tbody>
<tr>
<td>Cell #</td>
<td>Home #</td>
</tr>
<tr>
<td>Parent/Guardian #2</td>
<td>Email</td>
</tr>
<tr>
<td>Cell #</td>
<td>Home #</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact</th>
<th>Phone</th>
<th>Alternate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Doctor</td>
<td>Phone</td>
<td>Hospital</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is this student covered by private health care/ medical insurance and/ or Medicaid?</th>
<th>Yes</th>
<th>No</th>
<th>Medicaid #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Holder’s Name</td>
<td>Group Name</td>
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</table>

<table>
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<tr>
<th>Group #</th>
<th>Policy #</th>
</tr>
</thead>
</table>

INFORMATION CONCERNING PARTICIPATION IN SPORTS

By its very nature, competitive athletics puts students in situations in which serious, catastrophic, and sometimes fatal accidents and illnesses may occur. A student and his/her parents must assess the risks involved in participation in competitive athletics and make a decision concerning whether or not the student participates in spite of the risks. No amount of instruction, precaution, or supervision will totally eliminate the risk of death, injury, or illness associated with participation in athletic activities. The responsibility that parents and students have in making a choice to participate cannot be overstated. By granting permission for your child to participate in athletic competition and practice, you are acknowledging that you fully understand that such risks exist. Students will be instructed in the proper techniques to be used in athletic competition and practice and in the proper utilization of equipment worn or used in practices and competitions. Students must always adhere to that instruction and utilization, and must refrain from improper use or techniques. Again, no amount of instruction, precaution, & supervision will eliminate the risk of serious, catastrophic, and fatal injury or illness.

ADDITIONAL INFORMATION CONCERNING PARTICIPATION IN FOOTBALL

Football is a collision sport and injuries can, and do, occur. Safety is the major concern of the Rules Committees of the National Federation of State High School Associations. This document does not cover all potential injury possibilities in playing football, but it is an attempt to make players and their parents aware that fundamentals and proper-fitting equipment are important to student safety and enjoyment in playing football. By rule, the helmet is not to be used as a “ram.” Initial contact is not to be made with the helmet. However, it is not possible to play the game safely or correctly without making contact with the helmet when properly blocking and tackling and opponent. Therefore, technique is most important to prevention of injuries. Tackling and blocking techniques are basically the same. The play should always be in a position of balance: knees bent, back straight, body slightly bent forward, head up, target area as ear to the body as possible with the main contact being made with the shoulder. By not adhering to proper technique, injury could result in the shoulder and neck area, such as separation, pinched nerve, vertebral dislocation, nerve damage, paralysis, or even death. If any of the foregoing is not completely understood, please contact the school’s Athletic Director or Athletic Trainer for further information and clarification.

ACKNOWLEDGEMENT AND PARTICIPATION PERMISSION

As the parent/ legal guardian of ___________________________, I give my consent for his/her practice and play in the interscholastic program at MVCA, including travel to and from those athletic contests. I do not hold MVCA or its representatives (coaches, drivers, administrators, etc) responsible in any way whatsoever. I also grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or surgical treatment recommended by the emergency personnel designated by school authorities. I understand that every effort will be made to contact me prior to treatment. I certify that the medical history on the following pages is accurate to the best of my knowledge.

As an ATHLETE, I verify that I have read the MVCA Athletic Handbook. I agree that I will abide by the rules and guidelines while a member of a MVCA athletic team. I will do my best to maintain my grades to be eligible for participation.

As a PARENT/GUARDIAN of an MVCA student athlete, I verify that I have read the MVCA Athletic Handbook. I agree that I will help my student abide by these rules while a member of a MVCA athletic team.

- I have read and understand the above information, and I understand the risks involved with participating in interscholastic athletic activities, including practices.

STUDENT SIGNATURE: ___________________________ DATE: ____________

PARENT SIGNATURE: ___________________________ DATE: ____________
STUDENT’S NAME __________________________ GRADE 17-18 ______ SPORT _______________________

My student-athlete has permission to be transported to and from MVCA practices/events/contests via the following options:

• _____ Personal vehicle driven by the team coach.
• _____ Personal vehicle driven by a team parent.
• _____ Personal vehicle driven by another student-athlete.
  o My student is permitted to ride with the following driver(s) (Important – name must be listed)
    o ______________________________________
    o ______________________________________
    o ______________________________________

• _____ I give my student-athlete permission to drive other student-athletes to above functions.
• _____ Rental Bus driven by driver certified to transport student-athletes.
• _____ My athlete only has permission to ride with his/her own parents.

Parental Release Agreement
The undersigned parent(s) agree that their student may be provided transportation by those listed above to the said functions noted above. The undersigned further knowingly and voluntarily release and waive, and further agree to indemnify and hold harmless Miami Valley Christian Academy, school board members, administration, agents, employees, volunteers, representative successors or assigns thereof individually and in any capacity or relationship with or for any other, for or on account of any and all claims, including but not limited to, bodily injuries, and pain and suffering, which arises or may arise from the transportation of their student to and from the functions noted above.

Parent Signature __________________________________________________________ Date ______________________

Parent Printed Name ______________________________________________________
Preparticipation Physical Evaluation 2017-2018

Ohio High School Athletic Association

History Form – Please be advised that this paper form is no longer the OHSAA standard.

(Note: This form is to be filled out by the student and parent prior to seeing the medical examiner.)

Date of Exam __________________________

Name __________________________

Sex ______ Age ______ Grade ______ School __________________________

Address _______________________________________________________________________________________________________________________

Emergency Contact: _________________________________________________________________________________________

Relationship __________________________

Phone (H) ______ (W) ______ (Cell) ______ (Email) __________________________

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

Signature of Student __________________________ Signature of parent/guardian __________________________ Date: __________________________

The student has family insurance: ______ Yes ______ No ______ If yes, family insurance company name and policy number: __________________________________________________________________

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PLEASE COMPLETE ONLY IF YOUR STUDENT HAS SPECIAL NEEDS OR A DISABILITY.

Date of Exam
Name
Sex

Age
Grade
School

Sport(s)

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>6. Do you regularly use a brace, assistive device or prosthesis?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do you use a special brace or assistive device for sports?</td>
<td></td>
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<tr>
<td>8. Do you have any rashes, pressure sores, or any other skin problems?</td>
<td></td>
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<tr>
<td>9. Do you have a hearing loss? Do you use a hearing aid?</td>
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<tr>
<td>10. Do you have a visual impairment?</td>
<td></td>
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</tr>
<tr>
<td>11. Do you have any special devices for bowel or bladder function?</td>
<td></td>
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</tr>
<tr>
<td>12. Do you have burning or discomfort when urinating?</td>
<td></td>
<td></td>
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<tr>
<td>13. Have you had autonomic dysreflexia?</td>
<td></td>
<td></td>
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<tr>
<td>14. Have you ever been diagnosed with a heat related (hyperthermia) or cold-related (hypothermia) illness?</td>
<td></td>
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<tr>
<td>15. Do you have muscle spasticity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Do you have frequent seizures that cannot be controlled by medication?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Explain "yes" answers here

Please indicate if you have ever had any of the following.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocated joints (more than one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enlarged spleen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteopenia or osteoporosis</td>
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<td></td>
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<tr>
<td>Difficulty controlling bowel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bladder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in legs or feet</td>
<td></td>
<td></td>
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<tr>
<td>Weakness in arms or hands</td>
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<td></td>
</tr>
<tr>
<td>Weakness in legs or feet</td>
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<td></td>
</tr>
<tr>
<td>Recent change in coordination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in ability to walk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spina bifida</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latex allergy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 Student________________________________________________Signature of parent/guardian____________________________________________________________Date: ________________________
PHYSICIAN REMINDERS

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

2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

<table>
<thead>
<tr>
<th>EXAMINATION</th>
<th>DATE OF EXAMINATION</th>
</tr>
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<tbody>
<tr>
<td>Height</td>
<td>Weight</td>
</tr>
<tr>
<td>BP</td>
<td>(</td>
</tr>
<tr>
<td>Pulse</td>
<td>Vision R 20/</td>
</tr>
<tr>
<td>L20/</td>
<td>Corrected</td>
</tr>
<tr>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>NORMAL</td>
<td>ABNORMAL FINDINGS</td>
</tr>
</tbody>
</table>

PHYSICIAN REMINDERS

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

2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

- Consider ECG, echocardiogram, or referral to cardiology for abnormal cardiac history or exam.
- Consider GU exam if in private setting. Having third part present is recommended.
- Consider cognitive or baseline neuropsychiatric testing if a history of significant concussion.
CLEARANCE FORM

Note: Authorization forms (pages 5 and 6) must be signed by both the parent/guardian and the student.

Name ______________________________________ Sex □ M  □ F  Age __________  Date of birth ________________

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ____________________________________________________________

☐ Not Cleared

  ☐ Pending further evaluation

  ☐ For any sports

  ☐ For certain sports ____________________________________________________________

   Reason ________________________________________________________________

Recommendations ____________________________________________________________

__________________________________________________________________________

I have examined the above-named student and completed the pre-participation physical evaluation. The student does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. In the event that the examination is conducted en masse at the school, the school administrator shall retain a copy of the PPE. If conditions arise after the student has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician or medical examiner (print/type) ____________________________ Date of Exam ________________

Address ________________________________ Phone ____________________________

Signature of physician/medical examiner ____________________________________, MD, DO, D.C., P.A. or A.N.P.

EMERGENCY INFORMATION

Personal Physician ______________________ Phone ______________________

In case of Emergency, contact ______________________ Phone ______________________

Allergies ________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Other Information _________________________________________________________

________________________________________________________________________

________________________________________________________________________

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I hereby authorize the release and disclosure of the personal health information of _______________________________ ("Student"), as described below, to ____________________________________ ("School").

The information described below may be released to the School principal or assistant principal, athletic director, coach, athletic trainer, physical education teacher, school nurse or other member of the School's administrative staff as necessary to evaluate the Student's eligibility to participate in school sponsored activities, including but not limited to interscholastic sports programs, physical education classes or other classroom activities.

Personal health information of the Student which may be released and disclosed includes records of physical examinations performed to determine the Student's eligibility to participate in school sponsored activities, including but not limited to the Pre-participation Evaluation form or other similar document required by the School prior to determining eligibility of the Student to participate in classroom or other School sponsored activities; records of the evaluation, diagnosis and treatment of injuries which the Student incurred while engaging in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in school sponsored activities.

The personal health information described above may be released or disclosed to the School by the Student's personal physician or physicians; a physician or other health care professional retained by the School to perform physical examinations to determine the Student's eligibility to participate in certain school sponsored activities or to provide treatment to students injured while participating in such activities, whether or not such physicians or other health care professionals are paid for their services or volunteer their time to the School; or any other EMT, hospital, physician or other health care professional who evaluates, diagnoses or treats an injury or other condition incurred by the student while participating in school sponsored activities.

I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored and classroom activities, and that the School is a not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the School is covered under the federal regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.

I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student's participation in certain school sponsored activities may be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to the school principal (or designee) whose name and address appears below.

Name of Principal: ___________________________________________________________

School Address: ___________________________________________________________

This authorization will expire when the student is no longer enrolled as a student at the school.

NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS AUTHORIZATION PERSONALLY.

Student’s Signature

Birth date of Student, including year

Name of Student’s personal representative, if applicable

I am the Student’s (check one):     _______ Parent    _______ Legal Guardian (documentation must be provided)

Signature of Student’s personal representative, if applicable

Date

A copy of this signed form has been provided to the student or his/her personal representative
I have read, understand and acknowledge receipt of the OHSAA Student Athlete Eligibility Guide which contains a summary of the eligibility rules of the Ohio High School Athletic Association. I understand that a copy of the OHSAA Handbook is on file with the principal and athletic administrator and that I may review it, in its entirety, if I so choose. All OHSAA bylaws and regulations from the Handbook are also posted on the OHSAA website at ohsaa.org.

I understand that an OHSAA member school must adhere to all rules and regulations that pertain to the interscholastic athletics programs that the school sponsors, but that local rules may be more stringent than OHSAA rules.

I understand that participation in interscholastic athletics is a privilege not a right.

Student Code of Responsibility

As a student athlete, I understand and accept the following responsibilities:

- I will respect the rights and beliefs of others and will treat others with courtesy and consideration.
- I will be fully responsible for my own actions and the consequences of my actions.
- I will respect the property of others.
- I will respect and obey the rules of my school and laws of my community, state and country.
- I will show respect to those who are responsible for enforcing the rules of my school and the laws of my community, state and country.
- I understand that a student whose character or conduct violates the school’s Athletic Code or School Code of Responsibility is not in good standing and is ineligible for a period as determined by the principal.

Informed Consent – By its nature, participation in interscholastic athletics includes risk of injury and transmission of infectious disease such as HIV and Hepatitis B. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants have a responsibility to help reduce that risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. PARENTS, GUARDIANS OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN AN OHSAA-SPONSORED SPORT WITHOUT THE STUDENT’S AND PARENT’S/GUARDIAN’S SIGNATURE.

I understand that in the case of injury or illness requiring treatment by medical personnel and transportation to a health care facility, that a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be treated and transported via ambulance to the nearest hospital.

I consent to medical treatment for the student following an injury or illness suffered during practice and/or a contest.

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

I consent to the OHSAA’s use of the herein named student’s name, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.

I understand that if I drop a class, take course work through College Credit Plus, Credit Flexibility or other educational options, this action could affect compliance with OHSAA academic standards and my eligibility. I accept full responsibility for compliance with Bylaw 4-4-1, Scholarship, and the passing five credit standard expressed therein.

I understand all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. Further I understand that if my student is removed from a practice or competition due to a suspected concussion, he or she will be unable to return to participation that day. After that day written authorization from a physician (M.D. or D.O.) or an athletic trainer working under the supervision of a physician will be required in order for the student to return to participation.

I have read and signed the Ohio Department of Health’s Concussion Information Sheet and have retained a copy for myself.

By signing this we acknowledge that we have read the above information and that we consent to the herein named student’s participation.

*Must Be Signed Before Physical Examination*
Dear Parent/Guardian and Athletes,

This information sheet is provided to assist you and your child in recognizing the signs and symptoms of a concussion. Every athlete is different and responds to a brain injury differently, so seek medical attention if you suspect your child has a concussion. Once a concussion occurs, it is very important your athlete return to normal activities slowly, so he/she does not do more damage to his/her brain.

What is a Concussion?
A concussion is an injury to the brain that may be caused by a blow, bump, or jolt to the head. Concussions may also happen after a fall or hit that jars the brain. A blow elsewhere on the body can cause a concussion even if an athlete does not hit his/her head directly. Concussions can range from mild to severe, and athletes can get a concussion even if they are wearing a helmet.

Seek Medical Attention Right Away
Seeking medical attention is an important first step if you suspect or are told your child has a concussion. A qualified health care professional will be able to determine how serious the concussion is and when it is safe for your child to return to sports and other daily activities.

No athlete should return to activity on the same day he/she gets a concussion.
Athletes should NEVER return to practices/games if they still have ANY symptoms.
Parents and coaches should never pressure any athlete to return to play.

The Dangers of Returning Too Soon
Returning to play too early may cause Second Impact Syndrome (SIS) or Post-Concussion Syndrome (PCS). SIS occurs when a second blow to the head happens before an athlete has completely recovered from a concussion. This second impact causes the brain to swell, possibly resulting in brain damage, paralysis, and even death. PCS can occur after a second impact. PCS can result in permanent, long-term concussion symptoms. The risk of SIS and PCS is the reason why no athlete should be allowed to participate in any physical activity before they are cleared by a qualified healthcare professional.

Recovery
A concussion can affect school, work, and sports. Along with coaches and teachers, the school nurse, athletic trainer, employer, and other school administrators should be aware of the athlete’s injury and their roles in helping the child recover.

During the recovery time after a concussion, physical and mental rest are required. A concussion upsets the way the brain normally works and causes it to work longer and harder to complete even simple tasks. Activities that require concentration and focus may make symptoms worse and cause the brain to heal slower. Studies show that children’s brains take several weeks to heal following a concussion.

Be Honest
Encourage your athlete to be honest with you, his/her coach and your health care provider about his/her symptoms. Many young athletes get caught up in the moment and/or feel pressured to return to sports before they are ready. It is better to miss one game than the entire season… or risk permanent damage!
Returning to Daily Activities

1. Be sure your child gets plenty of rest and enough sleep at night – no late nights. Keep the same bedtime weekdays and weekends.
2. Encourage daytime naps or rest breaks when your child feels tired or worn-out.
3. Limit your child’s activities that require a lot of thinking or concentration (including social activities, homework, video games, texting, computer, driving, job-related activities, movies, parties). These activities can slow the brain's recovery.
4. Limit your child’s physical activity, especially those activities where another injury or blow to the head may occur.
5. Have your qualified health care professional check your child’s symptoms at different times to help guide recovery.

Returning to Learn (School)

1. Your athlete may need to initially return to school on a limited basis, for example for only half-days, at first. This should be done under the supervision of a qualified health care professional.
2. Inform teacher(s), school counselor or administrator(s) about the injury and symptoms. School personnel should be instructed to watch for:
   a. Increased problems paying attention.
   b. Increased problems remembering or learning new information.
   c. Longer time needed to complete tasks or assignments.
   d. Greater irritability and decreased ability to cope with stress.
   e. Symptoms worsen (headache, tiredness) when doing schoolwork.
3. Be sure your child takes multiple breaks during study time and watch for worsening of symptoms.
4. If your child is still having concussion symptoms, he/she may need extra help with school-related activities. As the symptoms decrease during recovery, the extra help or supports can be removed gradually.
5. For more information, please refer to Return to Learn on the ODH website.

Resources
ODH Violence and Injury Prevention Program
http://www.healthy.ohio.gov/vipp/child/returntoplay/
Centers for Disease Control and Prevention
http://www.cdc.gov/headsup/basics/index.htm
National Federation of State High School Associations
www.nfhs.org
Brain Injury Association of America
www.biausa.org/

Returning to Play

1. Returning to play is specific for each person, depending on the sport. Starting 4/26/13, Ohio law requires written permission from a health care provider before an athlete can return to play. Follow instructions and guidance provided by a health care professional. It is important that you, your child and your child’s coach follow these instructions carefully.
2. Your child should NEVER return to play if he/she still has ANY symptoms. (Be sure that your child does not have any symptoms at rest and while doing any physical activity and/or activities that require a lot of thinking or concentration).
3. Ohio law prohibits your child from returning to a game or practice on the same day he/she was removed.
4. Be sure that the athletic trainer, coach and physical education teacher are aware of your child’s injury and symptoms.
5. Your athlete should complete a step-by-step exercise-based progression, under the direction of a qualified healthcare professional.
6. A sample activity progression is listed below. Generally, each step should take no less than 24 hours so that your child’s full recovery would take about one week once they have no symptoms at rest and with moderate exercise.*

Sample Activity Progression*

Step 1: Low levels of non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: walking, light jogging, and easy stationary biking for 20-30 minutes).

Step 2: Moderate, non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: moderate jogging, brief sprint running, moderate stationary biking, light calisthenics, and sport-specific drills without contact or collisions for 30-45 minutes).

Step 3: Heavy, non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: extensive sprint running, high intensity stationary biking, resistance exercise with machines and free weights, more intense non-contact sports specific drills, agility training and jumping drills for 45-60 minutes).

Step 4: Full contact in controlled practice or scrimmage.

Step 5: Full contact in game play.

*If any symptoms occur, the athlete should drop back to the previous step and try to progress again after a 24 hour rest period.

http://www.healthy.ohio.gov/vipp/child/returntoplay/concussion

Rev. 09.16
Ohio Department of Health Concussion Information Sheet

For Interscholastic Athletics

I have read the Ohio Department of Health’s Concussion Information Sheet and understand that I have a responsibility to report my/my child’s symptoms to coaches, administrators and healthcare provider.

I also understand that I/my child must have no symptoms before return to play can occur.

________________________________________  ________________
Athlete                                      Date

________________________________________
Athlete  Please Print Name

________________________________________  ________________
Parent/Guardian                              Date

Ohio Department of Health

Rev. 9.16
What is Lindsay’s Law? Lindsay’s Law is about Sudden Cardiac Arrest (SCA) in youth athletes. It covers all athletes 19 years or younger who practice for or compete in athletic activities. Activities may be organized by a school or youth sports organization.

Which youth athletic activities are included in Lindsay’s law?

- Athletics at all schools in Ohio (public and non-public)
- Any athletic contest or competition sponsored by or associated with a school
- All interscholastic athletics, including all practices, interschool practices and scrimmages
- All youth sports organizations
- All cheerleading and club sports, including noncompetitive cheerleading

What is SCA? SCA is when the heart stops beating suddenly and unexpectedly. This cuts off blood flow to the brain and other vital organs. People with SCA will die if not treated immediately. SCA can be caused by 1) a structural issue with the heart, OR 2) an heart electrical problem which controls the heartbeat, OR 3) a situation such as a person who is hit in the chest or a gets a heart infection.

What is a warning sign for SCA? If a family member died suddenly before age 50, or a family member has cardiomyopathy, long QT syndrome, Marfan syndrome or other rhythm problems of the heart.

What symptoms are a warning sign of SCA? A young athlete may have these things with exercise:

- Chest pain/discomfort
- Unexplained fainting/near fainting or dizziness
- Unexplained tiredness, shortness of breath or difficulty breathing
- Unusually fast or racing heart beats

What happens if an athlete experiences syncope or fainting before, during or after a practice, scrimmage, or competitive play? The coach MUST remove the youth athlete from activity immediately. The youth athlete MUST be seen and cleared by a health care provider before returning to activity. This written clearance must be shared with a school or sports official.

What happens if an athlete experiences any other warning signs of SCA? The youth athlete should be seen by a health care professional.

Who can evaluate and clear youth athletes? A physician (MD or DO), a certified nurse practitioner, a clinical nurse specialist, certified nurse midwife. For school athletes, a physician’s assistant or licensed athletic trainer may also clear a student. That person may refer the youth to another health care provider for further evaluation.

What is needed for the youth athlete to return to the activity? There must be clearance from the health care provider in writing. This must be given to the coach and school or sports official before return to activity.

All youth athletes and their parents/guardians must review information about Sudden Cardiac Arrest, then sign and return this form.

----------------------------------------  ----------------------------------------
Parent/Guardian Signature                Student Signature

----------------------------------------  ----------------------------------------
Parent/Guardian Name (Print)             Student Name (Print)

----------------------------------------  ----------------------------------------
Date                                     Date
STUDENT ATHLETE AUTHORIZATION TO RELEASE INFORMATION

The content of my medical record is confidential and protected under state and federal law as per the HIPAA Notice of Privacy Practice posted in the school athletic training room. I understand that in an effort to provide quality athletic training services and maintain my safety, it is imperative that the athletic trainer for my school, who is employed by Drayer Physical Therapy Institute (DPTI), and any other DPTI employee who assists the athletic trainer with my care, keep other school related personnel informed, on a need to know basis, of my health care status and pertinent health care needs related to my participation in athletics.

Therefore, I, or my parent/legal guardian, hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Student Athlete’s Name: ___________________________ Date of Birth: ______________

Organization Providing the Information: DRAYER PHYSICAL THERAPY INSTITUTE

Organization(s) or Person(s) Receiving the Information: Head Coach, Assistant Coach(es), Athletic Director, Assistant Athletic Director, School Nurse, Physical Education Teacher, Equipment Manager, School Employed Athletic Trainer, Personal Trainer, Principal, Vice Principal(s), Student Athletic Trainers.

Other: ________________________________________________________________________________

Specific Description of Information Disclosed: √ Athletic Training Medical Record

Purpose of Disclosure: Coordination of Student Athlete’s Athletic Training and Medical Services in conjunction with participation in sports, Phys. Ed. Class and any other relevant School activities.

This Authorization is not for marketing purposes.

By signing and initialing the following statements, I authorize the release of such information to the persons listed above.

1. I understand this Authorization will expire 2 years from date of signature or on the following event: Termination of the student athlete/athletic trainer relationship. Initials: _____

2. I understand that I may revoke this Authorization at any time by notifying DPTI’s Privacy Officer in writing, but if I do, it will not have any effect on any actions DPTI took before they received the revocation. Initials: _____

(Authorize) ______________________________ Date ______________ Relationship to Student Athlete

Parent or Legal Guardian

You may refuse to sign this Authorization. We cannot condition treatment on your signing this Authorization.

By signing and initialing the following statements, I do not authorize the release of such information to the persons listed above.

1. I understand that by not signing this Authorization, I have limited the athletic trainers’ ability to release specific health information regarding injuries sustained or pre-existing conditions, on a need to know basis, to the persons listed above. Initials: _____

2. I have read and understand the purpose of this form and DO NOT authorize the release of such information to the persons listed above. Initials: _____

(Decline) ______________________________ Date ______________ Relationship to Student Athlete

Parent or Legal Guardian

For Internal Use Only

<table>
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<tr>
<th>Date Request is Made</th>
<th>Date of Release by DPTI (w/in 60 days of request)</th>
<th>Specific PHI Released (if other than entire record)</th>
<th>Released By (employee’s signature)</th>
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Drayer Physical Therapy Institute     8205 Presidents Drive Hummelstown, PA 17036     717-220-2100