HILLSIDE
PUBLIC SCHOOL DISTRICT
2018-2019
SPORTS PHYSICAL PACKET

ANY STUDENT WHO WOULD LIKE TO PARTICIPATE ON A MIDDLE SCHOOL OR HIGH SCHOOL SPORTS TEAMS MUST SUBMIT A COMPLETED SPORTS PHYSICAL PACKET TO BE ELIGIBLE

- **This is a LEGAL DOCUMENT- ONLY blue or black pen allowed.**
- **Parents/Guardians make sure you sign your name in all required spaces.**
- **Parents/Guardians if you take your child to your own doctor for a physical, please make sure the doctor completes all items on the physical including the cardiac assessment professional development module on page 6 and he/she must sign and use OFFICIAL DOCTOR OFFICE STAMP.**
- **EMERGENCY CARDS must be returned and completed in blue or black ink.**

Halim McNeil
Athletic Director
908-352-7664 x8440
1085 Liberty Ave.
Hillside, NJ 07205

SPORTS PERMIT

_____ _____

Student Athlete's Name (Print Clearly) Date

_____

Sport

I/we, the undersigned, give my permission to _____to participate in sports for the season of _____. I/we understand the insurance coverage is my/our obligation.

Realizing that such activity involves the potential for injury which is inherent in all sports, I/we acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observation of rules, injuries are still a possibility. On rare occasions these injuries can be so severe as to result in total disability, paralysis or even death. I/we acknowledge that I/we have read and understand this warning.

I/we give permission for the complete physical examination required prior to tryout/participation in this sport, to be given either by the school physician or our own physician. I hereby confirm that my Son/Daughter lives within the boundaries established for our school district.

Signature_____

Parent/Guardian

I, _____ a student in the Hillside Public Schools, hereby request permission to try out for_____during the season of _____.

Realizing that such activity involves the potential for injury which is inherent in all sports, I acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observation of rules, injuries are still a possibility. On rare occasions these injuries can be so severe as to result in total disability, paralysis or even death. I acknowledge that I have read and understand this warning.

I further promise to abide by all the rules and regulations set forth by the coach. All equipment that was issued to me will be turned in at the end of the season, or upon my leaving the squad and I will make full payment, immediately to the Director of Athletics for any missing equipment.

Signature_____

Student Athlete

Date of Birth _____ Address _____

Place of Birth _____ Grade _____

Height _____ Weight _____ Home Telephone _____

Family Physician _____ Parent/Guardian Cell _____

Physician's Telephone _____ Emergency Phone # (not parent) _____

REMINDER- Student Athletes must pass 30 credit hours per school year to be eligible for athletic participation. Student Athletes must pass 15 credit hours at the conclusion of the 2nd marking period to be eligible for spring sports.

CONSENT/REQUEST
FOR MEDICAL EXAMINATION BY SCHOOL PHYSICIAN

Date: _____ Grade: _____

Print Name of Student Athlete _____

Signature of Parent _____

~~Parent Home Phone~~ _____

Work Phone _____

Cell Phone _____

School Physician

I understand that the new code from the New Jersey Department of Education and Health NJAC 6A:16-2.2(h) requires that each student be examined for athletic participation by their Family/Primary Health Care Provider, with a full report sent to the school upon completion of the examination.

I am requesting that my child, _____, be examined by a School Physician appointed by the Hillside Board of Education.

I give my consent to the School Physician appointed by the Hillside Board of Education, to provide a physical examination for my child. I will be notified of any abnormal findings and will be responsible to seek further medical attention.

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

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 a copy of 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: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ 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: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ 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 _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PREPARTICIPATION PHYSICAL EVALUATION
THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

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

Explain "yes" answers here

_____

_____

_____

_____

_____

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

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

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 _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

NOTE: The preparticipation physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

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, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____ Weight _____ ☐ Male ☐ Female		
BP ___/___ (___/___) Pulse _____ Vision R 20/_____ L 20/_____ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ 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 preparticipation physical evaluation. The athlete 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. If conditions arise after the athlete has been cleared for participation, a 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, advanced practice nurse (APN), physician assistant (PA) (print/type) _____ Date of exam _____

Address _____ Phone _____

Signature of physician, APN, PA _____

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

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 _____

_____

_____

_____

_____

_____

EMERGENCY INFORMATION

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on _____
(Date)

Approved _____ Not Approved _____

Signature: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete 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. If conditions arise after the athlete 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, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

ATHLETIC TRAINING – SICKLE CELL QUESTIONAIRE

Sickle Cell Trait is the inheritance of one gene for sickle hemoglobin and one for normal hemoglobin. During intense or extensive exertion, the sickle hemoglobin can change the shape of red blood cells from round to quarter-moon or "sickle". These changes, called exertional sickling, can pose a grave risk to some athletes.

The sickle cell gene is common in peoples whose origins are from the areas where malaria is widespread. Over the millennium, carrying one sickle cell gene fended off death from malaria, leaving 1 in 12 African Americans with the sickle cell trait. The sickle gene is also present in the Mediterranean, Middle Eastern, Indian, Caribbean, South and Central American ancestry.

In the past seven years, exertional sickling has killed nine athletes ages 12-19. However, participation in athletics is allowed as long as proper precautions are followed to prevent such instances from occurring.

All 50 states screen for the Sickle Cell Trait at birth. The information should be available to you by your physician as part of your personal health information. If you are unsure of being tested or do not know your results, please contact your physician prior to answering the following questions.

_____ _____

Name Sport

1. Have you ever been tested for Sickle Cell Anemia? YES NO
   Date: _____ Results: _____
2. Have you ever been advised that you carry the Sickle Cell Trait or have Sickle Cell Anemia? YES NO
   Please describe: _____
3. Does any member of your family carry the Sickle Cell Trait or have Sickle Cell Anemia? YES NO
   Please describe: _____

Parent/Guardian's Signature _____

For more information on the Sickle Cell Trait and the athlete, please visit:
http://www.nata.org/sites/default/files/SickleCellTraitAndTheAthlete.pdf

INSURANCE FORM

Dear Parents/Guardians,

The Board of Education has purchased comprehensive insurance to protect in interscholastic athletics against accidental injury or death. Coverage is provided not only for athletes, but also for equipment managers, band members and cheerleaders.

PLEASE NOTE: This policy is in excess over any other insurance you may have. Thus, parents must use their OWN INSURANCE FIRST. This policy will then pick up the bills not covered by private insurance up to the limits in the policy. If you do not have insurance for medical expenses, this policy will go into effect immediately.

Although this coverage is very broad, there are restrictions, limitations and exclusions in the policy. In many situations, medical bills may not be covered in full. Parents should understand that medical expenses are their own responsibility.

Please report any injuries immediately to your child's coach, faculty advisor or athletic trainer. Claims will then be inputted into the system, but it will be the parent's responsibility to follow up utilizing the number below, collect all medical bills and submit them to the insurance company. Questions regarding the policy coverage or about the specific claims can be answered by Monarch management Corp/Axis Insurance Company.

MAGNA CARE
1-877-593-2872

Please acknowledge receipt of the attached certificate by signing and returning this letter to the coach or advisor.

Sincerely,

Antoine L. Gayles, Ed.D.

Superintendent of Schools

I/WE UNDERSTAND THAT THE INSURANCE COVERGE APPLIES ONLY AFTER PRIVATE INSURANCE HAS BEEN EXHAUSTED.

DATE:_____ SIGNATURE:_____

FERPA CONSENT FORM

Student Athlete's Name (Print Clearly) _____ Date _____

The Hillside Board of Education Medical Staff in order to be in compliance with the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA) require that the student athlete and parent or guardian read, understand and sign the following statements.

We hereby authorize the Hillside Board of Education Medical Staff and/or their insurance company to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and other needed information, included enrollment verification, concerning current or previous injuries and/or previous confinements and/or disabilities. A photo copy of this authorization shall be deemed as effective and valid as the original.

We understand that the Hillside Board of Education insurance policy only covers athletic injuries, and covers only those bills that are not covered by our insurance. We are ultimately responsible for all medical bills. We also understand that all injuries must be reported to the Hillside Board of Education Medical Staff in a timely manner. Hillside Board of Education is not responsible for injuries not reported. I hereby certify, swear, and affirm that the information given is true and accurate. I fully understand that any willful misrepresentation made by me in an attempt to collect benefits under the Hillside Board of Education Athletic Insurance Policy constitutes fraud and is punishable by law.

We authorize the Hillside Board of Education Medical Staff to assess, treat, rehabilitate, and refer me, if necessary, during the year. We further authorize the medical staff to disseminate selective information concerning my athletic injuries/health status to the appropriate athletic department staff members. This authorization can be revoked and/or modified in writing at any time by the student athlete, and or his/her parents or guardian. The student athlete has the right to specify what health information is released and to whom. This authorization will expire in one year. By not signing this authorization you will be disqualified from participation. This authorization does not allow any discussion of an athlete's medical condition with any type of media. If the student athlete has any questions concerning HIPAA or FERPA and "Privacy Rule" he/she should direct those questions to the Head Athletic Trainer.

Signature of Student Athlete _____ Date _____

Signature of Parent/Guardian _____ Date _____

State of New Jersey
DEPARTMENT OF EDUCATION

Sudden Cardiac Death Pamphlet

Sign-Off Sheet

Name of School District:_____

Name of Local School: _____

I/We acknowledge that we received and reviewed the Sudden Cardiac Death in Young Athletes pamphlet.

Student Signature: _____

Parent or Guardian
Signature:_____

Date: _____

New Jersey Department of Education 2014: pursuant to the Scholastic Student-Athlete Safety Act, P.L. 2013, c.71

E14-00395

NJSIAA

1161 Route 130, P.O. Box 487, Robbinsville, NJ 08691 609-259-2776 609-259-3047-Fax

NJSIAA STEROID TESTING POLICY

CONSENT TO RANDOM TESTING

In Executive Order 72, issued December 20, 2005, Governor Richard Codey directed the New Jersey Department of Education to work in conjunction with the New Jersey State Interscholastic Athletic Association (NJSIAA) to develop and implement a program of random testing for steroids, of teams and individuals qualifying for championship games.

Beginning in the Fall, 2006 sports season, any student-athlete who possesses, distributes, ingests or otherwise uses any of the banned substances on the attached page, without written prescription by a fully-licensed physician, as recognized by the American Medical Association, to treat a medical condition, violates the NJSIAA's sportsmanship rule, and is subject to NJSIAA penalties, including ineligibility from competition. The NJSIAA will test certain randomly selected individuals and teams that qualify for a state championship tournament or state championship competition for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents and his or her school. No student may participate in NJSIAA competition unless the student and the student's parent/guardian consent to random testing.

By signing below, we consent to random testing in accordance with the NJSIAA steroid testing policy. We understand that, if the student or the student's team qualifies for a state championship tournament or state championship competition, the student may be subject to testing for banned substances.

Signature of Student-Athlete	Print Student-Athlete's Name	Date

Signature of Parent/Guardian	Print Parent/Guardian's Name	Date

May 1, 2010

Sports-Related Concussion and Head Injury Fact Sheet and Parent/Guardian Acknowledgement Form

A concussion is a brain injury that can be caused by a blow to the head or body that disrupts normal functioning of the brain. Concussions are a type of Traumatic Brain Injury (TBI), which can range from mild to severe and can disrupt the way the brain normally functions. Concussions can cause significant and sustained neuropsychological impairment affecting problem solving, planning, memory, attention, concentration, and behavior.

The Centers for Disease Control and Prevention estimates that 300,000 concussions are sustained during sports related activities nationwide, and more than 62,000 concussions are sustained each year in high school contact sports. Second-impact syndrome occurs when a person sustains a second concussion while still experiencing symptoms of a previous concussion. It can lead to severe impairment and even death of the victim.

Legislation (P.L. 2010, Chapter 94) signed on December 7, 2010, mandated measures to be taken in order to ensure the safety of K-12 student-athletes involved in interscholastic sports in New Jersey. It is imperative that athletes, coaches, and parent/guardians are educated about the nature and treatment of sports related concussions and other head injuries. The legislation states that:

- All Coaches, Athletic Trainers, School Nurses, and School/Team Physicians shall complete an Interscholastic Head Injury Safety Training Program by the 2011-2012 school year.
- All school districts, charter, and non-public schools that participate in interscholastic sports will distribute annually this educational fact to all student athletes and obtain a signed acknowledgement from each parent/guardian and student-athlete.
- Each school district, charter, and non-public school shall develop a written policy describing the prevention and treatment of sports-related concussion and other head injuries sustained by interscholastic student-athletes.
- Any student-athlete who participates in an interscholastic sports program and is suspected of sustaining a concussion will be immediately removed from competition or practice. The student-athlete will not be allowed to return to competition or practice until he/she has written clearance from a physician trained in concussion treatment and has completed his/her district's graduated return-to-play protocol.

Quick Facts

- Most concussions do not involve loss of consciousness
- You can sustain a concussion even if you do not hit your head
- A blow elsewhere on the body can transmit an "impulsive" force to the brain and cause a concussion

Signs of Concussions (Observed by Coach, Athletic Trainer, Parent/Guardian)

- Appears dazed or stunned
- Forgets plays or demonstrates short term memory difficulties (e.g. unsure of game, opponent)
- Exhibits difficulties with balance, coordination, concentration, and attention
- Answers questions slowly or inaccurately
- Demonstrates behavior or personality changes
- Is unable to recall events prior to or after the hit or fall

Symptoms of Concussion (Reported by Student-Athlete)

- Headache
- Nausea/vomiting
- Balance problems or dizziness
- Double vision or changes in vision
- Sensitivity to light/sound
- Feeling of sluggishness or fogginess
- Difficulty with concentration, short term memory, and/or confusion

What Should a Student-Athlete do if they think they have a concussion?

- **Don't hide it.** Tell your Athletic Trainer, Coach, School Nurse, or Parent/Guardian.
- **Report it.** Don't return to competition or practice with symptoms of a concussion or head injury. The sooner you report it, the sooner you may return-to-play.
- **Take time to recover.** If you have a concussion your brain needs time to heal. While your brain is healing you are much more likely to sustain a second concussion. Repeat concussions can cause permanent brain injury.

What can happen if a student-athlete continues to play with a concussion or returns to play to soon?

- Continuing to play with the signs and symptoms of a concussion leaves the student-athlete vulnerable to second impact syndrome.
- Second impact syndrome is when a student-athlete sustains a second concussion while still having symptoms from a previous concussion or head injury.
- Second impact syndrome can lead to severe impairment and even death in extreme cases.

Should there be any temporary academic accommodations made for Student-Athletes who have suffered a concussion?

- To recover cognitive rest is just as important as physical rest. Reading, texting, testing-even watching movies can slow down a student-athletes recovery.
- Stay home from school with minimal mental and social stimulation until all symptoms have resolved.
- Students may need to take rest breaks, spend fewer hours at school, be given extra time to complete assignments, as well as being offered other instructional strategies and classroom accommodations.

Student-Athletes who have sustained a concussion should complete a graduated return-to-play before they may resume competition or practice, according to the following protocol:

- **Step 1**: Completion of a full day of normal cognitive activities (school day, studying for tests, watching practice, interacting with peers) without reemergence of any signs or symptoms. If no return of symptoms, next day advance.
- **Step 2:** Light Aerobic exercise, which includes walking, swimming, and stationary cycling, keeping the intensity below 70% maximum heart rate. No resistance training. The objective of this step is increased heart rate.
- **Step 3:** Sport-specific exercise including skating, and/or running: no head impact activities. The objective of this step is to add movement.
- **Step 4:** Non contact training drills (e.g. passing drills). Student-athlete may initiate resistance training.
- **Step 5:** Following medical clearance (consultation between school health care personnel and student-athlete's physician), participation in normal training activities. The objective of this step is to restore confidence and assess functional skills by coaching and medical staff.
- **Step 6:** Return to play involving normal exertion or game activity.

For further information on Sports-Related Concussions and other Head Injuries, please visit:

www.cdc.gov/concussion/sports/index.html www.nfhs.com
www.ncaa.org/health-safety www.bianj.org www.atsnj.org

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

Hillside High School

www.hillsidek12.org

Dr. Antoine Gayles
Superintendent

Dr. C. Oliver-Hawley
Director of Curriculum and Instruction

Halim McNeil
Athletic Director

CONSENT FORM FOR IMPACT TESTING

I, (Name of Parent/Guardian or Student Age 18 and over) _____ hereby consent to the administration of ImPACT testing for participation in athletics in the Hillside Public School District. I understand that the ImPACT testing provides baseline neurocognitive testing on student athletes and will provide significant data for return to competition decisions. This baseline data, along with physical examination, and/or further diagnostic testing, will help determine, as one measure, when it is safe for a student to return to competition, after a concussion (NJSIAA "Concussion Management Guidelines and Procedures", the description of ImPACT testing at http://www.impacttest.com and the District's website.)

I understand that a concussion is a mild traumatic brain injury. Concussion occurs when normal brain functioning is disrupted by a blow or jolt to the head, neck, face or chest. Recovery from concussion will vary. Avoiding re-injury and over-exertion from physical activity and cognitive activity, until fully recovered are the cornerstones of proper concussion management. I also understand that if my child sustains a concussion or head injury at a time other than when engaged in a school-sponsored activity, I must report the condition to the school nurse. I understand that ImPACT test results, written or otherwise, shall not be used for any purpose other than testing for cognitive functioning after symptoms of a concussion. I understand that the District will share ImPACT results with members of the Concussion Management Team ("CMT") in order to evaluate and manage student concussions for participation in District athletics but shall not otherwise release this information without my consent. I have fully reviewed The NJSIAA's Concussion Management Guidelines and Protocols and understand that, among other things, no student shall return to school or play while experiencing symptoms consistent with those of a head injury and that no student shall resume athletic activity until he/she has been symptom free for not less than twenty-four (24) hours.

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Student Name and Age: _____ Date: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Student Signature (If 18 or Older): _____

Hillside Public School District
Athletic Department
195 Virginia St.
Hillside, NJ 07205

The following information can be found online at
www.hillsidek12.org (Athletic Dept. Tab) or in the Nurse/Training offices

- Hillside Public School District Impact Consent Form
- Hillside Public School District Media Release form
- Hillside Public School District Athletic Code of Conduct
- Hillside Public School District Athlete Rules for Participation
- Hillside Public School District F.E.R.P.A. Consent Form
- Hillside Public School District Insurance Policy and Procedures
- N.J.S.I.A.A. Concussion Policy
- N.J.S.I.A.A. Steroid Testing Policy
- N.J.S.I.A.A. Sports Related Eye Injury information Packet
- N.J.S.I.A.A. Sudden Cardiac Death Pamphlet

By signing this document, I am affirming that I have read all materials, understand and agree with the policies and information. The reading of the policies or topics is mandatory for my child to participate in any sport within the State of NJ.

Parent/Guardian Signature_____

Student Signature _____

Date _____