HILLSIDE

2016-2017 SPORTS PHYSICAL PACKET

<u>ANY STUDENT WHO WOULD LIKE TO PARTICIPATE IN MIDDLE SCHOOL</u>

<u>OR HIGH SCHOOL SPORTS TEAMS</u>

<u>YOU NEED TO COMPLETE A SPORTS PHYSICAL</u>

- June is the only time that FREE PHYSICALS will be offered.
- This is a LEGAL DOCUMENT – only blue or black pen allowed.
- Parents/Guardians make sure your signature (cursive/script) is in all required spaces.
- Student athletes make sure you sign your name (cursive/script) in the correct locations.
- Parents/Guardians – if you take your child to your own doctor for a physical, please make sure the doctor completes what is on our form 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 x 8440
1085 Liberty Avenue
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 ____________________
Place of Birth ____________________
Height ________ Weight ________
Family Physician __________________
Physician's Telephone _____________

Address _________________________
Grade _________________________
Home Telephone ____________________
Parent/Guardian Cell __________________
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 ______

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HE0503 9-2681/0410

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 __________

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NOTE: The preparticiaption 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 ______________________________

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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 ______________________

____

____

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____

____

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 ______________________

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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 coverage to protect the participant 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 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 the medical expenses are their own responsibility, not the school.

Please report any injuries immediately to your child's coach, faculty advisor or athletic trainer. Claim forms will be provided by the school Athletic Director, but it will be the parent's responsibility to 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.

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

Sincerely,

Zende Clark

Superintendent of Schools

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

Date: ______________________________

Parent/Guardian Signature: ____________________________

PARENTS INSTRUCTIONS FOR FILING A CLAIM

The Student Accident insurance purchased by the Board of Education/School provides coverage on an EXCESS BASIS only. This means that only those with medical expenses, which are NOT covered by your own personal or group insurance (your primary insurance company), are eligible for coverage under this policy up to the limits therein.

Please follow these instructions when filing a claim:

1. CLAIMS MUST BE SUBMITTED ONLINE OR MAILED TO WebTPA WITHIN **90 DAYS** OF THE DATE OF THE ACCIDENT. Please be sure that:
   - A. The school official has completed his/her section of the claim form.
   - B. The Statement of Other Insurance section must be fully completed. If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.
2. IMMEDIATELY submit a claim for all medical expenses to the company that administers your own personal or group/employer insurance (including Major Medical coverage).
3. After your own insurance has paid the medical expenses up to the policy limits, submit itemized bills AND copies of the Explanation of Benefits from your primary insurance company as you receive them and mail to the address shown below. Balance due bills will not be accepted.
4. Please write the claimant's name, policy number and date of accident on all bills and Explanation of Benefits. A new claim form is not necessary when adding documentation to an existing claim.
5. Please keep a copy of any claim form.
6. If you need further information call 877-593-2872. DO NOT CALL THE SCHOOL or the ATHLETIC DEPARTMENT.

Thank you for your cooperation.

Network Provider

MAGNACARE℠

Plan Administrator & Claim Service By:

www.webtpa.com

8500 Freeport Pkwy South
Suite 400

Irving, TX 75063

Phone: (877) 5WEB-TPA

Fax: (469) 417-1970

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 ____________

ImPACT CONSENT FORM

The Hillside Public School system is currently implementing an innovative program for our student athletes. This program will assist our team physicians/athletic trainers in evaluating and treating head injuries (e.g. concussion). In order to better manage concussions sustained by our student athletes, we have acquired a software tool called ImPACT (Immediate Post Concussion Assessment and Cognitive Testing). ImPACT is a computerized exam utilized in many professional, collegiate, and high school sports programs across the country to successfully diagnose and manage concussions. If a student athlete is believed to have suffered a head injury during completion, ImPACT is used to help determine the severity of the head injury and when the injury has fully healed.

The computerized exam is given to student athletes before beginning contact sport practice or competition. This non-invasive test is set up in a "video-game" type format and takes about 15-20 minutes to complete. It is simple, and actually many student athletes enjoy the challenge of taking the test. Essentially, the ImPACT test is a preseason physical of the brain. It tracks information such as memory, reaction time, speed, and concentration. It however, is not an IQ test.

If a concussion is suspected, the student athlete will be required to re-take the test. Both the preseason and post-injury test data is given to a local doctor, neuropsychologist or a neurophysiologist. The information gathered can also be shared with your family doctor. The test data will enable these health professionals to determine when return to play is appropriate and safe for the injured student athlete. If an injury of this nature occurs to your child, you will be promptly contacted with all the details.

I wish to stress that the ImPACT testing procedures are non-invasive, and they pose no risks to your student athlete. If you have any further questions regarding this program please feel free to contact the Head Athletic Trainer. Participation in this program can be revoked and/or modified in writing at any time by the student athlete, and or his/her parents or guardian. By signing the signature page you are allowing your student athlete to participate in the ImPACT program.

I understand that this is a non-invasive test and that all results will be kept confidential and abide by all Family Education Rights and Privacy Act (FERPA) Guidelines.

NJSIAA PARENT/GUARDIAN CONCUSSION POLICY ACKNOWLEDGEMENT FORM

NJSIAA PARENT/GUARDIAN CONCUSSION POLICY ACKNOWLEDGMENT FORM In order to help protect the student athletes of New Jersey, the NJSIAA has mandated that all athletes, parents/guardians and coaches follow the NJSIAA Concussion Policy.

A concussion is a brain injury and all brain injuries are serious. They may be caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child/player reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:

1. Headache.
2. Nausea/vomiting.
3. Balance problems or dizziness.
4. Double vision or changes in vision.
5. Sensitivity to light or sound/noise.
6. Feeling of sluggishness or fogginess.
7. Difficulty with concentration, short-term memory, and/or confusion.
8. Irritability or agitation.
9. Depression or anxiety.
10. Sleep disturbance.

Signs observed by teammates, parents and coaches include:

1. Appears dazed, stunned, or disoriented.
2. Forgets plays or demonstrates short-term memory difficulties (e.g. is unsure of the game, score, or opponent) 3. Exhibits difficulties with balance or coordination.
4. Answers questions slowly or inaccurately.
5. Loses consciousness.
6. Demonstrates behavior or personality changes.
7. Is unable to recall events prior to or after the hit.

What can happen if my child/player keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences.
It is well known that adolescent or teenage athletes will often under report symptoms of injuries. And concussions are no different. As a result, education of administrators, coaches, parents and students is the key for student-athlete's safety.

If you think your child/player has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear. Close observation of the athlete should continue for several hours.

An athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time and may not return to play until the athlete is evaluated by a medical doctor or doctor of Osteopathy, trained in the evaluation and management of concussion and received written clearance to return to play from that health care provider.

You should also inform you child's Coach, Athletic Trainer (ATC), and/or Athletic Director, if you think that your child/player may have a concussion. And when it doubt, the athlete sits out. For current and up-to-date information on concussions you can go to:

www.cdc.gov/ConcussionInYouthSports
www.nfhslearn.com

Website Resources

- Sudden Death in Athletes
  http://tinyurl.com/m2gjmvq
- Hypertrophic Cardiomyopathy Association
  www.4hcm.org
- American Heart Association www.heart.org

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SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

The Basic Facts on Sudden Cardiac Death in Young Athletes

STATE OF NEW JERSEY
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SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

Sudden death in young athletes between the ages of 10 and 19 is very rare. What, if anything, can be done to prevent this kind of tragedy?

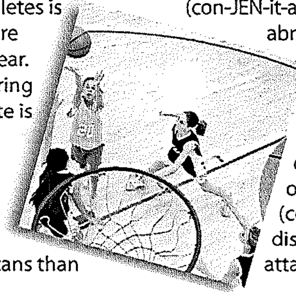
What is sudden cardiac death in the young athlete?

Sudden cardiac death is the result of an unexpected failure of proper heart function, usually (about 60% of the time) during or immediately after exercise without trauma. Since the heart stops pumping adequately, the athlete quickly collapses, loses consciousness, and ultimately dies unless normal heart rhythm is restored using an automated external defibrillator (AED).

How common is sudden death in young athletes?

Sudden cardiac death in young athletes is very rare. About 100 such deaths are reported in the United States per year. The chance of sudden death occurring to any individual high school athlete is about one in 200,000 per year.

Sudden cardiac death is more common: in males than in females; in football and basketball than in other sports; and in African-Americans than in other races and ethnic groups.



What are the most common causes?

Research suggests that the main cause is a loss of proper heart rhythm, causing the heart to quiver instead of pumping blood to the brain and body. This is called ventricular fibrillation (ven- TRICK-you-lar fib-roo-LAY-shun). The problem is usually caused by one of several cardiovascular abnormalities and electrical diseases of the heart that go unnoticed in healthy-appearing athletes.

The most common cause of sudden death in an athlete is hypertrophic cardiomyopathy (hi-per-TRO-fic CAR- dee-oh-my-OP-a-thee) also called HCM. HCM is a disease of the heart, with abnormal thickening of the heart muscle, which can cause serious heart rhythm problems and blockages to blood flow. This genetic disease runs in families and usually develops gradually over many years.

The second most likely cause is congenital (con-JEN-it-al) (i.e., present from birth) abnormalities of the coronary arteries. This means that these blood vessels are connected to the main blood vessel of the heart in an abnormal way. This differs from blockages that may occur when people get older (commonly called "coronary artery disease," which may lead to a heart attack).