New Paltz Central School District

Revised 6/22/12

ATHLETIC PERMISSION FORM

ATHLETE'S NAME_____

Your child indicated a desire to participate in sports for the current school year. Every student must be determined physically fit by a physician before being allowed to participate. If such an examination is conducted by other than the school physician, that physician must be licensed to practice in the State of NY and they must sign the school physical form, which must be placed in the health office. Participation in athletics can result in injury, sometimes serious injury, and in extreme cases, even death. With the parent/guardian signature, the parents/guardians authorize the coach to seek medical aid if their child is injured.

Your Board of Education feels the District and parents share in the responsibility of the young people participating in sport activities. Parents/Guardians must assume responsibility in the event of injury to the extent that their own health and accident insurance acts as a "primary carrier," the District's Accident and Health Insurance will assume responsibility as the "secondary carrier."

Valuable equipment will be issued to your child, and we expect that he/she will assume responsibility for its proper use and care. Failure to return this equipment at the conclusion of the season may result being billed, in exclusion from participation in future athletic programs and letters or awards may not be issued until such time as the equipment is returned.

Before participating in the first team meeting or practice, a student and his/her parents or guardians must have completed the Athletic Health History, Parent Permission, Interval Health History form, a Coaches Authorization card and a physical examination. Failure to complete any of the items listed above will disqualify a student from all practices and competition.

I hereby give my consent for _____ to participate in_____ for the current sports season. I agree that in case of injury or accident to my child while participating in this activity, I will assume full responsibility for any expenses covered by my own hospitalization insurance before requesting the school district to assume additional costs to the extent of its insurance coverage.

I AND MY PARENTS/ GUARDIANS HAVE READ THE ATHLETIC HANDBOOK and THE CONCUSSION INFORMATION,(contained in the HS handbook or attached) and this permission form, and **agree** to observe all rules, regulations and precautions which shall protect my own safety and that of other members of the group. We will always endeavor to conduct ourselves in a sportsmanlike manner, and shall assume responsibility for the proper use and care of all equipment. .

STUDENTS WHO PRACTICE AT THE MIDDLE SCHOOL ARE NOT PERMITTED TO CROSS RT 32 SOUTH (SOUTH MANHEIM BLVD) PRIOR TO, DURING OR AFTER TEAM PRACTICES. THE ONLY EXCEPTIONS ARE STUDENTS WHO NORMALLY WALK HOME AFTER SCHOOL AND/OR PRACTICES, *AND THEY MUST CROSS AT THE CROSSWALK AT THE CORNER.*
NO STUDENT MAY DRIVE TO AN OFF-SITE PRACTICE OR GAME !!

_____ _____ **Date:** _____

Signature of Parent/Guardian **Signature of Student**

Concussions: The Invisible Injury

Student and Parent Information Sheet

CONCUSSION DEFINITION

A concussion is a reaction by the brain to a jolt or force that can transmitted to the head by an impact or blow occurring anywhere on the body. Essentially a concussion results from the brain moving back and forth or twisting rapidly inside the skull.

FACTS ABOUT CONCUSSIONS ACCORDING TO THE CENTER FOR DISEASE CONTROL (CDC)

- An estimated 4 million people under age 19 sustain a head injury annually. Of these approximately 52,000 die and 275,000 are hospitalized.
- An estimated 300,000 sports and recreation related concussions occur each year.
- Students who have had at least one concussion are at increased risk for another concussion.

In New York State in 2009, approximately 50,500 children under the age of 19 visited the emergency room for a traumatic brain injury and of those approximately 3,000 were hospitalized.

REQUIREMENTS OF SCHOOL DISTRICTS

Education:

- Each school coach, physical education teacher, nurse, and athletic trainer will have to complete an approved course on concussion management on a biennial basis, starting with the 2012-2013 school year.
  - School coaches and physical education teachers must complete the CDC course. (www.cdc.gov/concussion/HeadsUp/online_training.html)
  - School nurses and certified athletic trainers must complete the concussion course. (http://preventingconcussions.org)

Information:

- Provide concussion management information and sign off with any parental permission form. **The NYSPHSAA will provide a pamphlet to member schools on the concussion management information for parents.**
- The concussion management and awareness information or the State Education Department's web site must be made available on the school web site, if one exists.

Removal from athletics:

- Require the immediate removal from athletic activities of any pupil that has or is believed to have sustained a mild traumatic brain injury.
- No pupils will be allowed to resume athletic activity until they have been symptom free for 24 hours and have been evaluated by and received written and signed authorization from a licensed physician. For interscholastic athletics, clearance must come from the school medical director.
  - Such authorization must be kept in the pupil's permanent heath record.
  - Schools shall follow directives issued by the pupil's treating physician.

SYMPTOMS

Symptoms of a concussion are the result of a temporary change in the brain's function. In most cases, the symptoms of a concussion generally resolve over a short period of time; however, in some cases, symptoms will last for weeks or longer. Children and adolescents are more susceptible to concussions and take longer than adults to recover.

It is imperative that any student who is suspected of having a concussion is removed from athletic activity (e.g. recess, PE class, sports) and remains out of such activities until evaluated and cleared to return to activity by a physician.

Symptoms include, but are not limited to:

- Decreased or absent memory of events prior to or immediately after the injury, or difficulty retaining new information
- Confusion or appears dazed
- Headache or head pressure
- Loss of consciousness
- Balance difficulties, dizziness, or clumsy movements
- Double or blurry vision
- Sensitivity to light and/or sound
- Nausea, vomiting and/or loss of appetite
- Irritability, sadness or other changes in personality
- Feeling sluggish, foggy or light-headed
- Concentration or focusing problems
- Drowsiness
- Fatigue and/or sleep issues – sleeping more or less than usual

Students who develop any of the following signs, or if signs and symptoms worsen, should be seen and evaluated immediately at the nearest hospital emergency room.

- Headaches that worsen
- Seizures
- Looks drowsy and/or cannot be awakened
- Repeated vomiting
- Slurred speech
- Unable to recognize people or places
- Weakness or numbing in arms or legs, facial drooping
- Unsteady gait
- Change in pupil size in one eye
- Significant irritability
- Any loss of consciousness
- Suspicion for skull fracture: blood draining from ear or clear fluid from the nose

STATE EDUCATION DEPARTMENT'S GUIDANCE FOR CONCUSSION MANAGEMENT

Schools are advised to develop a written concussion management policy. A sample policy is available on the NYSPHSAA web site at www.nysphsaa.org. The policy should include:

- A commitment to reduce the risk of head injuries.
- A procedure and treatment plan developed by the district medical director.
- A procedure to ensure proper education for school nurses, certified athletic trainers, physical education teachers, and coaches.
- A procedure for a coordinated communication plan among appropriate staff.
- A procedure for periodic review of the concussion management program.

RETURN TO LEARN and RETURN TO PLAY PROTOCOLS

Cognitive Rest: Activities students should avoid include, but are not limited to, the following:

- Computers and video games
- Television viewing
- Texting
- Reading or writing
- Studying or homework
- Taking a test or completing significant projects
- Loud music
- Bright lights

Students may only be able to attend school for short periods of time. Accommodations may have to be made for missed tests and assignments.

Physical Rest: Activities students should avoid include, but are not limited to, the following:

- Contact and collision
- High speed, intense exercise and/or sports
- High risk for re-injury or impacts
- Any activity that results in an increased heart rate or increased head pressure

Return to Play Protocol once symptom free for 24 hours and cleared by School Medical Director:

Day 1: Low impact, non strenuous, light aerobic activity.

Day 2: Higher impact, higher exertion, moderate aerobic activity. No resistance training.

Day 3: Sport specific non-contact activity. Low resistance weight training with a spotter.

Day 4: Sport specific activity, non-contact drills. Higher resistance weight training with a spotter.

Day 5: Full contact training drills and intense aerobic activity.

Day 6: Return to full activities with clearance from School Medical Director.

Any return of symptoms during the return to play protocol, the student will return to previous day's activities until symptom free.

CONCUSSION MANAGEMENT TEAM

Schools may, at their discretion, form a concussion management team to implement and monitor the concussion management policy and program. The team could include, but is not limited to, the following:

- Students
- Parents/Guardians
- School Administrators
- Medical Director
- Private Medical Provider
- School Nurse
- Director of Physical Education and/or Athletic Director
- Certified Athletic Trainer
- Physical Education Teacher and/or Coaches
- Classroom Teachers

OTHER RESOURCES

- New York State Education Department
- New York State Department of Health
http://www.health.ny.gov/prevention/injury_prevention/concussion/htm
- New York State Public High School Athletic Association
www.nysphsaa.org/safety/
- Center for Disease Control and Prevention
http://cdc.gov/concussions
- National Federation of High Schools
www.nfhslearn.com – The FREE Concussion Management course does not meet education requirement.
- Child Health Plus
http://www.health.ny.gov/health_care/managed_care/consumer_guide/about_child_health_plus.htm
- Local Department of Social Services – New York State Department of Health
http://www.health.ny.gov/health_care/medicaid/ldss/htm
- Brain Injury Association of New York State
http://www.bianys.org
- Nationwide Children's Hospital – Concussions in the Classroom
http://www.nationwidechildrens.org/concussions-in-the-classroom
- Upstate University Hospital – Concussions in the Classroom
http://www.upstate.edu/pmr/healthcare/programs/concussion/classroom.php
- ESPN Video – Life Changed by Concussion
http://espn.go.com/video/clip?id=7525526&categoryid=5595394
- SportsConcussions.org
http://www.sportsconcussions.org/ibaseline/
- American Association of Neurological Surgeons
http://www.aans.org/Patient%20Information/Conditions%20and%20Treatment/Concussion.aspx
- Consensus Statement on Concussion in Sport – Zurich
http://sportconcussions.com/html/Zurich%20Statement.pdf

(PRESS FIRMLY)

NEW PALTZ CENTRAL SCHOOLS
COACH'S AUTHORIZATION FOR TEAM MEMBERSHIP AND PARTICIPATION

Student's Name _____ Sport & Level _____
PLEASE PRINT

Date of Birth _____ Grade _____ Age _____ Emergency Medical Info _____
(MM/DD/YY)

Home Tel. No. _____ Cell No. _____ Business Tel. No. _____

Family Physician's
Name & Tel. No. _____

Emergency Contact
Name & Tel. No. _____

This card indicates:

1. The parent/guardian's permission form is on file with the A.D.
2. The pre-participation evaluation has been completed.
3. The sports physical has been completed and the above named student is approved for athletic participation.
4. The parent/guardian has authorized the coach to seek medical aid if the student is injured.

Nurse's Signature _____ Date _____

Athletic Director's Signature _____ Date _____

Both signatures are requested prior to any practice or participation in an interscholastic athletic activity.

White: Nurse's Copy Yellow: Athletic Director's Copy Buff: Coach's Copy

PRE-PARTICIPATION/INTERVAL ATHLETIC HEALTH HISTORY – Two Page Form

New Paltz Central School District

School Name: _____

Student Name: _____ DOB: ____/____/_____

Grade (check): ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12

Sport: _____ Level (check): ❑ Varsity ❑ JV ❑ Modified

Date of last health exam: _____/_____/_____Limitations: ❑ Yes ❑ No Date form completed____/____/_____

Health History To Be Completed By Parent/Guardian

Answer questions below to indicate if your child has or has ever had the following and provide details to any yes answer on back:

Question	YES	NO
Has a doctor or nurse practitioner (a health care provider) ever restricted his/her participation in sports for any reason?		
Does s/he have an ongoing medical condition? Please check below: □ Asthma □ Diabetes □Seizures □ Other □ Sickle Cell trait or disease		
Has s/he ever had surgery?		
Has s/he ever spent the night in a hospital?		
Does s/he have a life threatening allergy? Please check below: □ Medication □ Food □ Insect bites □ Pollen □Latex □ Other		
Does s/he carry an Epi-pen (epinephrine)?		
Has s/he ever passed out during or after exercise?		
Has s/he ever complained of light headedness or dizziness during or after exercise?		
Has s/he ever complained of chest pain, tightness or pressure during or after exercise?		
Has s/he ever complained of fluttering in their chest, skipped beats, or their heart racing, or does s/he have a pacemaker?		
Has a health care provider ever ordered a test for his/her heart? (ex. EKG, echocardiogram, stress test)		
Has s/he been told s/he has a heart condition or problem?		
Has s/he ever had high or low blood pressure?		
Has s/he ever complained of getting more tired or short of breath than his/her friends during exercise?		
Does s/he wheeze or cough frequently during or after exercise?		
Has a health care provider ever said s/he has asthma?		
Does s/he use or carry an inhaler or nebulizer?		
Has s/he ever become ill while exercising in hot weather?		
Is s/he on a special diet or have to avoid certain foods?		
Does s/he worry about their weight?		
Question	**YES**	**NO**
Does s/he have stomach problems?		
Has s/he ever had a hit to the head that caused a headache, dizziness, nausea, or confusion, or been told s/he had a concussion?		
Does s/he ever have headaches with exercise?		
Has s/he ever had a seizure?		
Is s/he currently being treated for a seizure disorder or epilepsy?		
Has s/he ever been unable to move his/her arms and legs, or had tingling, numbness, or weakness after being hit or falling?		
Has s/he ever an injury, pain, or swelling of joint that caused him/her to miss practice or a game?		
Does s/he use a brace, orthotic or other device?		
Does s/he have any problems with his/her hearing or wear hearing aides?		
Does s/he have any problems with his/her vision or have vision in one eye only?		
Does s/he wear glasses or contacts?		
Has s/he ever had a hernia?		
Does s/he have only 1 functioning kidney?		
Does s/he have a bleeding disorder?		
Females Only	**YES**	**NO**
Has she had her period? At what age did it begin? _____		
How often does she get her period?		
Date of last menstrual period_____		
Males Only	**YES**	**NO**
Does he have only one testicle?		
Family History	**YES**	**NO**
Has any relative been diagnosed with a heart condition or developed hypertrophic cardiomyopathy, Marfan Syndrome, right ventricular cardiomyopathy, long QT or short QT syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
Has any relative died suddenly before the age of 50 from unknown or heart related cause?		

PLEASE FILL IN BOTH SIDES OF THIS SHEET

PREPARTICIPATION/INTERVAL ATHLETIC HEALTH HISTORY – Page 2

School Name: _____

Student Name: _____ DOB: ____/____/_____

Please explain fully any question you answered yes to in the space below (Please print clearly, and provide dates if known):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I certify that to the best of my knowledge my answers are complete and true.

_____

Parent/Guardian signature

_____

Date

PLEASE FILL IN BOTH SIDES OF THIS SHEET