August 12, 2022

Dear Physicians, Athletic Directors and School Medical Personnel:

The Committee on Sports Medicine of the Iowa Medical Society is updating the Pre-Participation Physical Evaluation (PPE) form starting the 2022-2023 sports seasons. This updated form was revised and created for the participants in Iowa High School Athletics in order to be most current in best practices of screening and identifying health concerns of the student athlete that are relevant to their safe participation. The information used for this update was from the Pre-Participation Physical Evaluation, 5th Edition, published in 2019. The updated form and plans for transition were shared with the Iowa Association of School Boards for review and input prior to dissemination.

Below are some brief highlights of changes to the attached form:

- Expanded Format-The form is now 4 pages instead of 2 pages.
- Mental Health Screening
- Expanded Adolescent Safety Questions
- Updated Health Questions and Physical Examination
- Confidentiality and Format Changes

SPECIAL NOTE: **Page 4 of this form is ALWAYS turned in to the school for participation/clearance and emergency contact information**. This page can be used by any and all personnel of the school.

However, due to HIPAA/FERPA regulations, a licensed health care professional and confidential storage of the sports physical form pages 1 through 3 is necessary, if those pages are to be kept at the school and used for medical purposes. Otherwise, pages 1 through 3 can be kept with the provider who performs the Pre-participation Examination and a waiver should be signed for release of information by the student athlete and parent if this is required by the school for participation of the student athlete. (*Ref: 5th Edition of Pre-Participation Physical Examination, 2019, pgs 25-27*)

We appreciate your understanding in these updates and changes to mirror best practices in the Pre-Participation Examination. By working together in this, we can help to provide the safest environment for participation of our student athletes.

IOWA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

Please complete and sign this form (with your parents if younger than 18) before your appointment.

Name: ______________________________ Date of Birth: ______________________

Date of Examination: ______________________________ Sport(s): ______________________

Home Address (Street, City, Zip): ______________________________ School District: ______________________

Parent's/Guardian's Name: ______________________________ Phone #: ______________________

Physician: ______________________________ Phone #: ______________________

History Form:

List past and current medical conditions.

____

Have you ever had a surgery? If "yes", list all past surgical procedures.

____

Medicines and Supplements: List all current prescriptions, over-the-counter medicines and supplements (herbal and nutritional).

____

Do you have any allergies? If yes, please list all your allergies (to medicines, pollen, food, stinging insects, etc.)

____

PHQ-4: Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle Response)

	Not at all	Several Days	Over half the days	Nearly Everyday
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [Questions 1 and 2, or Questions 3 and 4] for screening purposes)

SCORE: ____

In the section below, if you answer "yes" to any questions, please explain further in the space provided at the end of this form. Circle any questions you don't know the answer to.

General Questions:

Y N

☐ ☐ Do you have any concerns that you would like to discuss with your provider?

☐ ☐ Has a provider ever denied or restricted your participation in sport for any reason?

☐ ☐ Do you have any ongoing medical issues or recent illnesses?

Heart Health Questions:

Y N

☐ ☐ Have you ever passed out of nearly passed out during or after exercise?

☐ ☐ Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?

☐ ☐ Does your heart ever race, flutter in your chest or skip beats (irregular beats) during exercise?

☐ ☐ Has a doctor ever told you that you have any heart problems?

☐ ☐ Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography?

☐ ☐ Do you get lightheaded or feel shorter of breath than your friends during exercise?

☐ ☐ Do you have high blood pressure or high cholesterol?

Questions about your Family:

Y	N	
☐	☐	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?
☐	☐	Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia (CPVT)?
☐	☐	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?
☐	☐	Does anyone in your family have asthma?

Bone and Joint Questions:

Y	N	
☐	☐	Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?
☐	☐	Have you had an X-ray, MRI, CT scan or physical therapy for any reason?
☐	☐	Do you have a bone, muscle, ligament or joint injury that bothers you?
☐	☐	Do you currently, or have you in the past worn orthotics, braces or protective equipment for any reason?

Medical Question:

Y	N	
☐	☐	Do you cough, wheeze or have difficulty breathing during or after exercise?
☐	☐	Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?
☐	☐	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?
☐	☐	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?
☐	☐	Have you had a concussion? Or a head injury that caused confusion, a prolonged headache, or memory problems?
☐	☐	Have you ever had a seizure?
☐	☐	Do you get frequent headaches?
☐	☐	Have you ever had numbness, tingling, weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?
☐	☐	Have you ever become ill when exercising in the heat?
☐	☐	Do you have sickle cell trait or disease? Or anyone in your family?
☐	☐	Have you ever had or do you have any problems with your eyes or vision?
☐	☐	Do you worry about your weight?
☐	☐	Are you trying to or has anyone recommended that you gain or lose weight?
☐	☐	Are you on a special diet or do you avoid certain types of foods or food groups?
☐	☐	Have you ever had an eating disorder?

FEMALES only:

Y	N	
☐	☐	Have you ever had a menstrual period?
☐	☐	How old were you when you had your first menstrual period?
☐	☐	When was your most recent menstrual period?
☐	☐	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 questions on this form are complete and correct.

Signature of Athlete: ______________________________

Signature of Parent or Guardian: ______________________________ Date: ____________________

Physical Examination *(To be filled out by medical provider)*

Consider additional questions as below:

Y	N	
☐	☐	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, e-cigarettes, chewing tobacco, snuff or dip?
☐	☐	Do you drink alcohol or use any other drugs?
☐	☐	Have you taken prescriptions medications that were not yours or outside of their intended use?
☐	☐	Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
☐	☐	Have you ever taken any supplements to help you gain or lose weight or improve your performance?
☐	☐	Do you wear a seat belt and a helmet?
☐	☐	Do you use condoms if you are sexually active?

EXAMINATION

Height: ________________ Weight: _______________

BP: _____ / _____ (____/ ____) Pulse: ________ Vision: R 20/____ L 20/ ____ Corrected Y / N

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency)		
Eyes, ears, nose and throat • Pupils equal & Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, auscultation supine, and ± Valsalva)		
Lungs		
Abdomen		
Skin • Herpes Simplex Virus, lesions suggestive of MRSA or Tinea Corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder & Arm		
Elbow & Forearm		
Wrist, hand, and fingers		
Hip & Thigh		
Knee		
Leg & Ankle		
Foot & Toes		
Functional • May include: Duck Walk, Double-leg squat test, single-leg squat test, and box drop or step drop test		

- Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings or a combination of those.

Medical Eligibility Form

Student Athlete Name: ____________________ Date of Birth: ____________ Date of Examination: ____________

I acknowledge and give consent for a copy of this entire form to be kept in the student's school record. I agree that should student's health change in any way that would alter this form that I will inform the school as soon as possible. .

Signature of Parent or Guardian: ____________________ Date: ____________

Shared Emergency Information *(To be filled out by athlete/athlete's caregiver)*

Allergies:

____

Medications:

____

Other Information:

____

Emergency Contacts:

Name	Relationship	Contact Information

Participation Eligibility *(To be filled out by medical provider)*

☐ Medically Eligible for sports without restriction.

☐ Medically Eligible for all sports without restriction with recommendations for further evaluation or treatment of:

____

☐ Medically eligible for certain sports:

____

☐ Not medically eligible pending further evaluation

____

☐ Not medically eligible for any sports

Recommendations:

____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined in this form. A copy of the physical examination findings 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 provider may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print): ____________________ Date: ____________

Address: ____________________ Phone: ____________

Signature of health care professional:

____

Preparticipación Atlético Examen Físico, Actualización

Articulo VII 36.14 (1) Examen Físico. Todos los años cada estudiante (grados 7'12) presentará al supervisor del estudiante un certificado firmado por un médico y el cirujano licenciados, médico y cirujano osteopáticos, el osteópata, enfermero registrado avanzado (ARNP), ayudante de médico o médico calificado de la quiropráctica, al efecto que el estudiante se ha examinado y puede entrar seguramente en la competencia atlético. Este certificado de examen físico es válido para los propósitos de esta regla para uno (1) calendario año. Un periodo de gracia, no exceder treinta (30) días, es permitido para certificaciones expiradas de examen físico.

Cuestionario para la Participación Atlético (por favor escribe a máquina o imprime ordenadamente esta información)

Nombre__________________________ Masculino____ Hembra____ Fecha del nacimiento____________ Grado_____

Domicilio____________________________________ Distrito Escolar__________________

Nombre de padre/guardián________________________ Fecha________ Numero del teléfono____________

Médico de la familia________________________ Teléfono del médico______________________

HISTORIA DE LA SALUD (Las preguntas siguientes deben ser completadas por el estudiante-atleta con la ayuda de un padre o guardián. Un padre o el guardián son requeridos a firmar en al otro lado de esta forma después que el examen físico se completa.)

Si No ¿Tenga este estudiante tuvo cualquiera…

1 __ __ Alergia medicinas, al polen, los insectos, comida?
2 __ __ Enfermedad que dura más de una (1) semana?
3 __ __ El Asma o dificultad que respira durante ejercicio?
4 __ __ Enfermedad o la herida que es crónica o recurrente?
5 __ __ La Diabetes?
6 __ __ Epilepsia u otros ataques?
7 __ __ Llevar lentes o lentillas?
8 __ __ La infección del herpes o MRSA?
9 __ __ Hospitalizaciones (de noches o más largo)?
10 __ __ El Síndrome de Marfan?
11 __ __ Perdiendo órganos (ojo, un riñón, un testículo)?
12 __ __ La fiebre Reumática, el mononucleosis?
13 __ __ Las tomas o frecuenta dolores de cabeza?
14 __ __ La cirugía?
****
15 __ __ Presión en el pecho, dolor o sensación de opresión con el ejercicio?
16 __ __ El mareo o desmayar con ejercicio?
17 __ __ Dolores de cabeza, mareos o desmayos durante, o después de hacer ejercicio?
18 __ __ Los problemas cardíacos (compitiendo, el murmullo, golpes saltados, la infección, etc.)?
19 __ __ La hipertensión o el colesterol alto?

Si No ¿Tenga este estudiante tuvo cualquiera…

20 __ __ La herida en la cabeza, la conmoción, la inconsciencia?
21 __ __ La herida en la cabeza, la conmoción, la inconsciencia?
22 __ __ El entumecimiento, sentir hormigueo, o la debilidad en armamentos o piernas con contacto?
****
23 __ __ El músculo severo obstaculiza o se enferma al ejercitar en el calor?
****
24 __ __ Fractura, la fractura por sobrecarga o articulación dislocada?
25 __ __ Las heridas que requieren el tratamiento médico?
26 __ __ La herida de rodilla o la cirugía de rodilla?
27 __ __ La herida del cuello?
28 __ __ Aparatos ortopédicos, aparatos ortopédicos, equipos de protección?
29 __ __ Otras heridas articulación graves?
30 __ __ Doloroso abultamiento o hernia en la ingle?
31 __ __ Rayos X, resonancia magnética, tomografía computarizada, terapia física?
****
32 __ __ Un médico ha negado nunca o restringido su participación en los deportes por cualquier razón?
33 __ __ ¿Tiene alguna duda que le gustaría discutir con su proveedor de atención médica?

Si No Historia de Familia

34 __ __ ¿En su familia tiene cualquiera síndrome de Marfan?
35 __ __ ¿Ha alguien de su familia murió de problemas cardíacos o cualquier motivo inesperado/inexplicada antes de la edad de 50 años?
36 __ __ ¿Alguien en su familia tiene un problema cardíaco, marcapasos o desfibriladores implantables?
37 __ __ ¿Tiene alguien en su familia había inexplicable desmayo, convulsiones, o cerca de ahogarse?
38 __ __ ¿Alguien en su familia tiene asma?
39 __ __ ¿Usted o alguien de su familia tienen rasgo de células falciformes o la enfermedad?

Utilice este espacio para explicar cualquiera del encima de numerado "sí" respuestas (preguntas #1-38) o para proporcionar información adicional: ____________________________________

40 ¿Es usted alérgico a cualquier prescripción o medicinas sin receta? Si sí, lista: __________________

41 Lista todos medicinas que usted actualmente está tomando (incluir inhalantes de asma y EpiPens) y la condición que la medicina es para-
A ________________ B ________________ C ________________

42 Año del último conocido- El tétano inyección ________ Vacunación de Meningitis ________ Vacunación de Influenza ________

43 ¿Qué es el más y menos usted ha pesado en el año pasado? Mayoría ____________ Menos____________

44 ¿Está usted contento con su peso actual? Sí ________ No________

PARA MUJERES SOLO-

1. ¿Cuántos años tenía cuando usted tuvo su primer período menstrual?________________
2. En el año pasado, ¿qué es el tiempo más largo que usted ha ido entre períodos menstruales?________________

Registro Físico del Examen (Ser completado por un médico de profesional licenciado como designado en el Artículo VII 36.14(1). Esta evaluación es de sólo determinar la prontitud para la participación de deporte. No se debe utilizar como un substituto para exámenes regulares de salud.

Nombre de atleta______________________________________ La altura_________ Peso_________

Pulso_________ Tensión______/______ (Repita si anormal ______/______) la Visión R 20/____ L 20/____

	NORMALES	CONCLUSIONES ANORMALES	INICIALAN
1. La apariencia (esp. Marfan's)			
2. Los ojos/orejas/nariz/garganta			
3. El tamaño del alumno (Iguala/no igual)			
4. La boca & dientes			
5. El cuello			
6. Nodos de linfa			
7. El corazón (Parándose & Mintiendo)			
8. Pulsos (esp. Femoral)			
9. El pecho & pulmones			
10. El abdomen			
11. Pele			
12. Los genitales-Hernia			
13. El músculo esquelético-ROM, la fuerza, etc. (Vea las preguntas 24-28)			
14. Neurológico			

Los comentarios con respecto a conclusiones anormales - __________________________________

La Recomendación Atlética de la Participación de los Licenciados Médicos Profesionales

______**REPLETO & ILIMITADA PARTICIPACION**

______**LIMITO PARTICIPACION**-NO puede tomar parte en el siguiente (verificó)

____Béisbol ____Baloncesto ____A campo través ____Fútbol americano ____Golf ____Fútbol

____Béisbol para chicas ____Natación ____Tenis ____pista(correr) ____Voleibol ____Lucha

____Lanzamiento

____**Espacio Libre pendiente documentado sigue de**______________________________

____**No aprobado para la Participación Atlética debido a:** ____________________________

______________________________________ ________________

Nombre de Médico Licenció Profesional (Imprimió) La Fecha

______________________________________ ________________

Firma de Médico Licenció Profesional Numero del teléfono

El permiso y la liberación de los Padres o el Guardián (Firme después del examen físico se ha completado.)

Yo verifique la certeza de la información en el lado opuesto de esta forma y doy mi consentimiento para el estudiante denominado para entrar en actividades atléticas aprobados como un representante de su escuela, menos que esas actividades indicadas por encima del profesional licenciado. Doy también mi permiso para el médico del equipo, entrenador atlético, u otro personal calificado para dar los primeros auxilios el tratamiento a mi hijo o la hija en un acontecimiento atlético en caso de la herida.

____________________________ ____________________________

El nombre del padre/guardián (Imprimió) Firma del padre/guardián

____ ________________

Dirección de domicilio (Apartados de correos de calle, la ciudad, el estado, la cremallera) El numero del teléfono

Esta forma se ha desarrollado con la ayuda del Comité en la Medicina de Deporte del Iowa la Sociedad Médica y ha sido aprobada para el uso por el Departamento de Iowa de la Educación, Iowa Educa Alto la Asociación Atlética, Chicas de Iowa Educan Alto Unión Atlética. Las escuelas son favorecidas a no cambiar esta forma de su formato publicado. Las formas adicionales de la escuela ciertamente pueden ser conectadas a esta forma.

STUDENT ACTIVITIES PROGRAM
NEWELL-FONDA CSD

Dear Parents/Guardian/Student:

The attached form must be completed and on file in the respective school office **BEFORE** participation in the first practice or event can be permitted.

The purpose of the form is as follows:

1. To authorize the student to participate in the program.
2. To assure the school that the parent/guardian/student has read the policies governing the student activities program.
3. To acknowledge that there can be some hazards involved with participating.
4. To verify the student is covered by insurance for those activities which require insurance coverage (athletics, cheerleading, and dance team).

We appreciate your completion of this form. If you have any questions concerning this form, please contact the school.

This form along with the physical examination form, concussion form, and consent for medical treatment card **MUST BE** on file in the office before a student may start practice.

Thank you,
Christopher Feldhans, High School Principal
Bo Darrow, PK-8 Principal

NEWELL-FONDA
PARENT/STUDENT ACKNOWLEDGEMENT & RELEASE FORM
FOR STUDENT ACTIVITIES
GRADES: 7-12

Parents/Guardians/Students: Please read carefully and complete:

This form MUST be completed and on file in the respective school office before participation in the first practice or event will be permitted. In athletics along with cheerleading and dance team, a completed and current physical examination must also be on file.

Student's Name: ______________________________ Grade: ________ School Year: ________

1. I/We hereby give my/our consent for the above student to participate in the students' activities programs of Newell-Fonda CSD.

2. I/We have read the policies stated in the Student Activities Code and understand them fully. I/We agree that my/our son/daughter will abide by these policies while he/she is involved in the activity covered in the code and are aware of the consequences for any violation of the policies.

3. I/We give my/our permission for the above-named student to participate in activities programs, realizing that such activities involve the potential for injury which is inherent in all activities. I/We acknowledge that even with the best coaching/sponsoring the use of the most advanced protective equipment and strict observance of rules, injuries are still possible. 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 acknowledge this warning.

   Parent(s)/Guardian(s) Signature: ______________________________ Date: __________

4. INSURANCE: All participants in athletics, cheerleading, and dance team must have some type of family health/accident insurance coverage or must purchase an alternate policy.

   ____ My/Our child is covered by a family health/accident insurance plan.

   I/We will purchase the alternate insurance policy available through the school. (This may be purchased in addition to family coverage.)

   I/We understand that the school DOES NOT carry insurance to cover medical expenses incurred while participating and I/we will assume all such expenses personally. (Note: Examine your insurance policy carefully to make sure they cover interscholastic athletic participation).

   Parent(s)/Guardian(s) Signature: ______________________________ Date: __________

Students: Please read carefully.

I have received a copy of the Students' Activity Code and have read the policies governing the activities program and understand them. I will abide by the policies while I am involved in the activities at Newell-Fonda, and I am aware of the consequences for violating the policy.

By my participation in the organized activities, I realize that such activity involves the potential for injury which is inherent in all activities. I acknowledge that even with the best coaching/sponsoring, using the most advanced protective equipment and strict observance of the rules, injuries are still a possibility. And on rare occasions these injuries can be so severe as to result in total disability, paralysis, or even death.

Student's Signature: ______________________________ Date: __________

HEALTH AND INJURY INFORMATION CARD and CONSENT FOR MEDICAL TREATMENT FORM

(This form is to be completed and kept available for reference wherever competition takes place. Update medical information as necessary.)

Student's Name (Last, First, MI) ______________________________

Age________ Grade_______ Date of Birth____________ Today's Date ______________

Parent's/Guardian's Name______________________________

Student's Address______________________________

Parent's/Guardian's Home Phone Number______________________________

Father's/Guardian's Place of Work______________________________

Father's/Guardian's Work Phone Number______________________________

Mother's/Guardian's Place of Work______________________________

Mother's/Guardian's Work Phone Number______________________________

In an emergency, when parent's/guardian's cannot be notified, please contact:

______________________________ Relationship____________________ Phone______________

______________________________ Relationship____________________ Phone______________

Family Physician______________________________ Phone______________

Preferred Hospital______________________________ Phone______________

Family Dentist______________________________ Phone______________

Date of last tetanus booster: ______________________ (month/year)

Do you wear: Glasses ________yes ________no / Contacts ________yes ________no / Dentures ________yes ________no

List any known allergies, drug reactions, or other pertinent medical information. (Diabetes, seizures, history of head injury with unconsciousness or confusion, medications, etc.)

____

____

____

Please note and date any new injury information here: ______________________________

____

____

CONSENT FOR MEDICAL TREATMENT

Iowa law requires a parent's, or legal guardian's, written consent before their son or daughter can receive emergency treatment, unless, in the opinion of a physician, the treatment is necessary to prevent death or serious injury.

As the parent(s), or legal guardian(s), of the child named on the front of this card, I (we) authorize emergency medical treatment or hospitalization that is necessary in the event of an accident or illness of my (our) child. I (we) understand that this written consent is given in advance of any specific diagnosis or hospital care. *This written authorization is granted only after a reasonable effort has been made to contact me (us).*

______________ ______________________________

Date Parent's/Guardian's signature

Consent for Treatment endorsed by the Iowa Chapter of the American Academy of Emergency Physicians

Cards provided by THE IOWA HIGH SCHOOL ATHLETIC ASSOCIATION, BOONE, IA

A FACT SHEET FOR PARENTS AND STUDENTS

HEADS UP: Concussion in High School Sports

Please note this important information based on Iowa Code Section 280.13C, Brain Injury Policies:

(1) A student participating in extracurricular interscholastic activities, in grades seven through twelve, **must be immediately removed from participation** if the coach, contest official, licensed healthcare provider or emergency medical care provide believe the student has a concussion based on observed signs, symptoms, or behaviors.

(2) Once removed from participation for a suspected concussion, the **student cannot return to participation until written medical clearance has been provided** by a licensed health care provider.

(3) A student cannot return to participation until s/he is free from concussion symptoms at home and at school.

(4) Definitions:

"Contest official" means a referee, umpire, judge, or other official in an athletic contest who is registered with the Iowa high school athletic association or the Iowa girls high school athletic union.

"Licensed health care provider" means a physician, physician assistant, chiropractor, advanced registered nurse practitioner, nurse, physical therapist, or athletic trainer licensed by a board.

"Extracurricular interscholastic activity" means any extracurricular interscholastic activity means any dance or cheerleading activity or extracurricular interscholastic activity, contest, or practice governed by the Iowa high school athletic association or the Iowa girls high school athletic union that is a contact or limited contact activity as identified by the American academy of pediatrics.

"Medical clearance" means written clearance from a licensed health care provider releasing the student following a concussion or other brain injury to return to or commence participation in any extracurricular interscholastic activity.

What is a concussion?

Concussions are a type of brain injury that disrupt the way the brain normally works. Concussions can occur in any sport or recreational activity and can result from a fall or from players colliding with each other, the ground, or obstacles. Concussions can occur with or without loss of consciousness, but most concussions occur without loss of consciousness.

What parents/guardians should do if they think their child has a concussion?

1. Teach your child that it's not smart to play with a concussion.
2. **OBEY THE LAW.**
   a. Seek medical attention right away.
   b. Keep your child out of participation until s/he is cleared to return by a licensed healthcare provider.
3. Tell all of your child's coaches, teachers, and school nurse about ANY concussion.

What are the signs and symptoms of concussion?

Signs and symptoms of concussion can show up right after the injury or may not be noticed until days after the injury. If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be removed from play immediately. The athlete should only return to play with permission from a health care provider and after s/he is symptom free at home and at school.

Signs Observed by Parents or Coaches:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

Symptoms Reported by Student-Athlete:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

STUDENTS, If you think you have a concussion:

- **Tell your coaches & parents** – Never ignore a bump or blow to the head, even if you feel fine. Also, tell your coach if you think one of your teammates might have a concussion.
- **Get a medical check-up** – A physician or other licensed health care provider can tell you if you have a concussion, and when it is OK to return to play.
- **Give yourself time to heal** – If you have a concussion, your brain needs time to heal. While your brain is healing, you are much more likely to have another concussion. It is important to rest and not return to play until you get the OK from your health care professional.

PARENTS/GUARDIANS, You can help your child prevent a concussion:

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.

For more information visit: **www.cdc.gov/Concussion**

IMPORTANT: Students (grades 7-12) participating in interscholastic athletics, cheerleading and dance; and their parents/guardians; must annually sign the acknowledgement below and return it to their school. Students cannot practice or compete in those activities until this form is signed and returned.

We have received the information provided on the concussion fact sheet titled, "HEADS UP: Concussion in High School Sports."

Student's Signature ____________ Date ____________ Student's Printed Name ____________

Parent's/Guardian's Signature ____________ Date ____________ Student's Grade ____________ Student's School ____________