



West Campus High School

5022 58th Street, Sacramento, CA 95820

The following information is needed for your child to participate in athletics at West Campus High School.

1. Medical Clearance (RSK-F100C). Parents fill out the top portion before taking the form to a health care provider. If the health care provider uses his/her own, please attach it to the SCUSD form (physicals must be dated after July 1, 2018 and are good from July 2018 – July 2019).
2. Agreement for Team Participation (RSK-100A). Fill out the front and the back. **Please provide medical insurance information on the back page.** If you do not have insurance, you can access Student Insurance information and applications at www.k12specialmarkets.com.
3. CIF Concussion Information Sheet. Parent and athlete sign and date.
4. Play It Safe Concussion Care Consent/Release of Information Form
5. West Campus Student Athlete Emergency Information. You must include the name and number of at least three emergency contacts.
6. Athletic Packet Checklist

Please return the completed packet to Mary Lucca in room 32.

Thank you,

Mary Lucca
West Campus High School
Athletic Director
916-277-6400 ext 1132
mary-lucca@scusd.edu

2018 - 2019 WEST CAMPUS ATHLETICS CLEARANCE FORMS IMPORTANT INFORMATION

Dear Parents,

Welcome to the 2018 - 2019 season of West Campus Athletics! The athletic training staff is looking forward to working with your student athletes to help everyone have a healthy and successful season. The certified athletic trainer is here to assist in the evaluation and management of any sport related injuries sustained by student athletes. This individual has specific education and training that includes orthopedic evaluation, first aid, taping and bracing, injury rehabilitation and emergency first response. The athletic trainer is available every day after school (room 64) and attends all the home games to provide medical coverage for your athletes. Please encourage your athletes to see the athletic trainer if they are having trouble participating in their sport due to injury. Our athletic trainer is here to help.

Before your son or daughter is able to participate, we need some information from you. Please complete the following forms and return them to the athletic trainer, the athletic director, or the box in the front office marked "Athletics" before the first team tryout or practice. **Your child will not be eligible to participate in tryouts, training sessions, team practices, or games until his/her completed packet is received.** This packet only needs to be completed once a year. If your child plays more than one sport, you do not need to turn in this packet more than once. His/her emergency information will be passed on to the coach of their next sport.

1. **Medical Clearance Form – RSK-F100C:** A physical must be performed every school year. The school year begins July 1, 2018. Only evaluations performed by a Medical Doctor (MD), Doctor of Osteopathy (DO), Physicians Assistant (PA) or Nurse Practitioner (NP) will be accepted. A physical by a chiropractor is NOT acceptable. The physical form contains a section that requires your child's medical history information and your signature in addition to a section that must be completed by your healthcare practitioner. Please make sure the physical form is completely filled out before submitting the packet.
2. **Agreement for Team Participation – RSK-100A:** Please review this agreement with your student athlete to ensure understanding. These agreements are necessary for successful athletic participation. The form is two pages, please be sure to complete the information at the top of the first page AND sign the bottom of the second page.
3. **California Interscholastic Federation (CIF) Concussion Information Sheet:** This form contains important information regarding our policy on concussion and head injury management. Please review it carefully with your student athlete, and make sure you both sign it.
4. **Play It Safe Concussion Care Consent Consent/Release of Information Form:** This form provides consent for your student athlete to undergo a baseline ImPACT (Immediate test Post-concussion Assessment and Cognitive Testing) computer test. This test is an incredibly important tool for proper management of a concussion. It provides information that helps us to determine precisely when your child is ready to return to play if they sustain a concussion.

- 5. Student Athlete Emergency Information:** If an athlete is seriously hurt and a parent cannot be contacted, someone else must be notified. Therefore, having at least three (3) different contact numbers is essential. Please be sure to complete the Insurance Company and Identification Number information. This information is important should an athlete need to be transported by ambulance. A copy of the student's insurance card is preferred for verification purposes. Be sure to sign and verify your insurance information. If your son/daughter does not have insurance coverage, insurance must be purchased through SCUSD prior to any activity.

Lastly, please review the following protocol regarding physician referral. It is extremely important that all parents, coaches and athletes understand and adhere to this protocol.

Protocol regarding physician referral: The athletic trainer may refer an athlete to a physician should he/she feel it is necessary. This protocol will be followed to rule out a fracture or if an athlete is not progressing with the treatment and rehabilitation that has been implemented. If the athletic trainer feels a condition needs a doctor's consultation, he/she will contact the coach and the parent to explain the present concern. The athlete will not be cleared to play until the physician states this in writing. This policy is to protect the athlete from further injury.

If an athlete is seen by a physician for further evaluation, whether taken directly by a parent OR referred by the athletic trainer, it is **ABSOLUTELY NECESSARY** that the athlete returns with a note from the physician stating the athlete's diagnosis, treatment and participation status. If the athlete is referred by the athletic trainer, a medical referral form will be sent with the athlete and must be filled out completely by the physician before an athlete will be cleared to play. Without such a note/form the athletic trainer can only presume that the athlete has not been cleared to participate and will not be allowed to return to his/her sport until a medical clearance is received from the physician.

If you have any questions or concerns, please contact me. Thank you!

Mary Lucca
Athletic Director
West Campus High School
mary-lucca@scusd.edu

West Campus High School

Athletic Packet Checklist

THIS FORM MUST BE RETURNED WITH YOUR CLEARANCE PACKET TO THE ATHLETIC DIRECTOR BEFORE CLEARANCE IS GRANTED.

NAME _____ GRADE _____

ARE YOU A TRANSFER STUDENT? YES NO

FALL SPORT	
WINTER SPORT	
SPRING SPORT	

DO NOT WRITE BELOW THIS LINE

FORM	CLEARED	NOT CLEARED
EMERGENCY INFORMATION – 3 CONTACTS		
MEDICAL CLEARANCE (RSK-F100C) – DATED AFTER JULY 1, 2018		
AGREEMENT FOR TEAM PARTICIPATION (RSK-100A)		
CIF CONCUSSION AND INFORMATION SHEET		
PLAY IT SAFE CONCUSSION PERMISSION TEST DATE _____		

**2018 – 2019 WEST CAMPUS ATHLETICS
STUDENT ATHLETE EMERGENCY INFORMATION**

NAME: _____ Class of 20____ SPORT(S): _____

ADDRESS: _____
(CITY) (ZIP CODE)

DATE OF BIRTH: _____ SEX: M F

PLEASE COMPLETE THE FOLLOWING WITH THE MOST RELIABLE CONTACT NUMBER

PARENT/GUARDIAN NAME: _____ PHONE: (____) _____ (H W C)

PARENT/GUARDIAN NAME: _____ PHONE: (____) _____ (H W C)

If parents/guardians **CANNOT** be reached in an emergency, please contact: *(please provide 2 additional contacts)*

1. _____ Relationship to student: _____

PHONE: (____) _____ (H W C) – circle one

2. _____ Relationship to student: _____

PHONE: (____) _____ (H W C) – circle one

Does the athlete have medical insurance? Yes No

Medical Insurance Company: _____ Policy # _____

My son/daughter currently has or has had any of the following health conditions: Yes or No

Diabetes _____ Epilepsy _____ Heart Condition _____ Asthma _____

Drug Allergy (state drug) _____ Other (state condition) _____

I, hereby:

- attest that all of the above information given is true.
- give my consent, in case this student is injured or becomes ill, for the school and/or its representative to secure medical aid, ambulance transportation, and for the medical agency to render treatment.
- give my consent to the team physician, athletic trainer and/or coach to apply first aid treatment until the emergency personnel can be contacted.
- acknowledge that I have read and clearly understand the policy regarding physician referrals provided in the athletics clearance form cover letter.

Parent Signature

Date

School Site: _____

School Year: 2018/2019

Sacramento City Unified School District

PART 1 (TO BE COMPLETED BY A PARENT OR LEGAL GUARDIAN)

LAST NAME		FIRST NAME			GRADE
BIRTHDATE	FALL SPORT	WINTER SPORT	SPRING SPORT	STUDENT ID NUMBER	

PART 1 – HEALTH HISTORY (Must be Completed by Parent/Guardian Prior to the Examination)

	Yes	No	Has this student had:		Yes	No	
1.	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or recurrent illness?	16.	<input type="checkbox"/>	<input type="checkbox"/>	Injuries requiring medical care or treatment?
2.	<input type="checkbox"/>	<input type="checkbox"/>	Illness lasting over 1 week?	17.	<input type="checkbox"/>	<input type="checkbox"/>	Neck or back pain or injury?
3.	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalizations or Surgeries?	18.	<input type="checkbox"/>	<input type="checkbox"/>	Knee pain or injury?
4.	<input type="checkbox"/>	<input type="checkbox"/>	Nervous, psychiatric, or neurologic condition?	19.	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder or elbow pain or injury?
5.	<input type="checkbox"/>	<input type="checkbox"/>	Loss or nonfunctioning of organs (eye, kidney, liver, testicle) or glands?	20.	<input type="checkbox"/>	<input type="checkbox"/>	Ankle pain or injury?
6.	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (medicines, insect bites, food)?	21.	<input type="checkbox"/>	<input type="checkbox"/>	Other joint pain or injury?
7.	<input type="checkbox"/>	<input type="checkbox"/>	Problems with heart or blood pressure?	22.	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones (fractures)?
8.	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain or significant or severe shortness of breath during or after exercise?	23.	<input type="checkbox"/>	<input type="checkbox"/>	Does this student presently:
9.	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting with exercise?	24.	<input type="checkbox"/>	<input type="checkbox"/>	Wear eyeglasses or contact lenses?
10.	<input type="checkbox"/>	<input type="checkbox"/>	Fainting, bad headaches or convulsions?	25.	<input type="checkbox"/>	<input type="checkbox"/>	Wear dental bridges, braces or plates?
11.	<input type="checkbox"/>	<input type="checkbox"/>	Potential concussion or loss of consciousness?	26.	<input type="checkbox"/>	<input type="checkbox"/>	Take any medications? (List below):
12.	<input type="checkbox"/>	<input type="checkbox"/>	Heat exhaustion, heatstroke, or other problems managing or responding to heat?	27.	<input type="checkbox"/>	<input type="checkbox"/>	Further history:
13.	<input type="checkbox"/>	<input type="checkbox"/>	Racing heartbeat, skipped or irregular heartbeats, or heart murmur?	28.	<input type="checkbox"/>	<input type="checkbox"/>	Birth defects (corrected or not)?
14.	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or seizure disorders?	29.	<input type="checkbox"/>	<input type="checkbox"/>	Death of a parent or grandparent less than 40 years of age due to medical cause or condition?
15.	<input type="checkbox"/>	<input type="checkbox"/>	Severe or repeated instances of muscle cramps?				Parent or grandparent requiring treatment for heart condition less than 50 years of age?
							Been seen by a physician on an emergency or urgent basis in the last 12-months?

Date of last known tetanus (lockjaw) shot: _____ Date of last complete physical examination: _____
 Explain all "YES" answers. Describe any other fact that should be disclosed prior to the examination (use reverse of form if needed):

PARENT/GUARDIAN'S AUTHORIZATION: I authorize the health care provider to perform a Sports Physical Evaluation on the student. The information set forth above is complete and accurate. I presently know of no reason why the student cannot fully and safely participate in the listed sports. For Sports Physical Evaluations that may be performed by District volunteers, I understand the evaluation is a screening evaluation only, and that I must address all health care concerns with the Student's personal physician or health care provider.

PRINT NAME OF PARENT OR GUARDIAN		SIGNATURE OF PARENT OR GUARDIAN		
ADDRESS	WORK PHONE	HOME PHONE	DATE	
REGULAR PHYSICIAN'S NAME	OFFICE PHONE			

PART 2 – MEDICAL EVALUATION (TO BE COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER)
 This Evaluation Can Only be Performed by Medical Doctors (MDs), Doctors of Osteopathy (DOs), Physician's Assistants (P.A.s), and Nurse Practitioners (N.P.s)

	NORMAL	ABNORMAL (Describe)	(May be contained on Provider's Form)
Eyes/Ears/Nose/Throat			Height: _____ Weight: _____
Heart, lungs, pulmonary function			Pulse: _____ After Ex: _____
Abdomen, genital/hernia (males)			BP: _____
Skin and Musculoskeletal:			Recommendation: <input type="checkbox"/> Unlimited participation <input type="checkbox"/> Limited participation/specific sports, events or activities <input type="checkbox"/> Clearance withheld pending further testing/evaluation <input type="checkbox"/> No athletic participation One of the above MUST be checked.
a. Neck/Spine/Shoulders/Back			
b. Arms/Hands/Fingers			
c. Hips/Thighs/Knees/Legs			
d. Feet/Ankles			
Neurologic Screening Exam (NSE)/			
Concussion Screening Evaluation (only if needed based on above info.)			

Comments:

PRINT NAME OF PHYSICIAN	PHYSICIAN'S SIGNATURE	DATE
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AGREEMENT FOR TEAM PARTICIPATION

[Including Waivers and Releases of Potential Claims and Statement of Other Obligations]

All sections of this Agreement must be completed, with the signed original delivered to the School office, before a Student will be allowed to participate in any manner in the Team Activities defined below. A separate Agreement is required for each Team in which the Student may participate.

Name of Student	Address:
Grade:	DOB:
School:	Telephone:
Team:	

In consideration for the Student’s ability to participate on the Team [including any Sport, Cheerleading, Dance, or Marching Band], including try outs for the Team, participation in Team practices or training sessions, the receiving of coaching, training, or direction, the participation in Team events, shows, performances, or competitions, or the traveling to and from any of the foregoing activities (“Team Activities”), the Student and the Parent or Legal Guardian (“Adult”) signing this Agreement agree as follows:

1. It is a privilege, not a right, to participate in extra-curricular activities, including Team Activities. The privilege may be revoked at any time, for any reason, that does not violate Federal, State or District laws, policies or procedures. There is no guarantee that the Student will make the Team, remain on the Team, or actively participate in Team events, shows, performances, or competitions. Such matters shall remain exclusively within the judgment and discretion of the District and its employees.

2. The Student and the Adult understand the nature of the Team, including the inherent or potential risks of Team Activities. The Student is in sufficiently good health and physical condition to participate in Team Activities, and voluntarily wishes to participate in Team Activities. Before participating in a Team Activity, a medical clearance shall be submitted (valid for one calendar year), signed by a licensed physician, or physician-supervised and authorized nurse practitioner or physician’s assistant, stating that the Student has been physically examined and is deemed to be in sufficiently good health and fitness so that the Student may fully participate in Team Activities.

3. The Student shall comply with the instruction and directions of Team Activity teachers, coaches, supervisors, chaperones, and instructors. During the Student’s participation in Team Activities, as well as academic and/or other school activities, the Student shall comply with all applicable Codes of Conduct. The Student shall also generally conduct himself/herself at all times in keeping with the highest moral and ethical standards so as to reflect positively on himself/herself, the Team and the District. Failure to meet these obligations may, in the discretion of the District, result in immediate removal from Team Activities and a prohibition against any future involvement in Team Activities or other extra-curricular activities. Should the violation of these obligations also result in bodily injury or property damage during a Team Activity, the Adult will (a) pay to restore or replace any property damaged as a result of the Student’s violation, (b) pay any damages caused to bodily injury to an individual, and (c) defend, protect and hold the District harmless from such property damage or bodily injury claims.

4. Team Activities contain potential risks of harm or injury, including harm or injury that may lead to permanent and serious physical injury to the Student, including paralysis, brain injury, or death (“Injuries”) Injuries might arise from the Student’s actions or inactions, the actions or inactions of another Student or participant in a Team Activity, or the actual or alleged failure by District employees, agents or volunteers to adequately coach, train, instruct, or supervise Team Activities. Injuries might also arise from an actual or alleged failure to properly maintain, use, repair, or replace physical facilities or equipment available for Team Activities. Injuries might also arise from undiagnosed, improperly diagnosed, untreated, improperly treated, or untimely treated actual or potential Injuries, whether or not caused by the Student’s participation in Team Activities. All such risks are deemed to be inherent to the Student’s participation in Team Activities. By this Agreement, the Student and Adult are deemed to fully assume all such risks and, in consideration for the right of the Student to participate in Team Activities, understand and agree that to the fullest extent allowed by law they are waiving and releasing any potential future claim they might otherwise have been able assert against the District, or any Board Member, employee, agent or volunteer of the District (“Released Parties”) by or on behalf of the Student or any parent, administrator, executor, trustee, guardian, assignee or family member, and further understand that transportation to or activities at another location are “field trips” or “excursions” for which there is complete immunity pursuant to Education Code § 35330.

5. If the Student believes that an unsafe condition or circumstance exists, or otherwise feels or believes that continued participation in Team Activities might present a risk of Injury, the Student will immediately discontinue further participation in Team Activities, notify School personnel of the Student’s belief, and notify a parent or guardian of the Student’s belief. Any parent or guardian of the Student shall, thereafter, not allow the Student to participate in Team Activities until the unsafe condition or circumstance is remedied, with any question or concern regarding the alleged existence of the unsafe condition or circumstance addressed to their satisfaction.

6. Emergency medical information regarding the Student is on file with the District and is current. The Adult agrees to provide updated medical information during the course of the Student's participation in Team Activities. If an injury or medical emergency occurs during Team Activities, District employees, agents or volunteers have my express permission to administrator or to authorize the administration of urgent or emergency care, including the transportation of the Student to an urgent care or emergency care provider. In such circumstances, notice to me and/or the Emergency Contact of the injury or medical emergency may be delayed. Therefore, any urgent or emergency care provider has my express authority to conduct diagnostic or anesthetic procedures, and/or to provide medical care or treatment (including surgery), as they may deem reasonable or necessary under all existing circumstances. All costs and expenses associated with such care are solely my responsibility.

7. Education Code Section 32221.5 requires us to notify you that: "Under state law, school districts are required to ensure that all members of school athletic teams have accidental injury insurance that covers medical and hospital expenses. This insurance requirement can be met by the school district offering insurance or other health benefits that cover medical and hospital expenses. Some pupils may qualify to enroll in no-cost or low-cost local, state, or federally sponsored health insurance programs. Information about these programs may be obtained by calling the District." Education Code Section 32221 requires that such insurance cover medical and hospital expenses resulting from bodily injuries in one of the following amounts: (a) a group or individual medical plan with accident benefits of at least \$200 for each occurrence and major medical coverage of at least \$10,000, with no more than \$100 deductible and no less than 80% payable for each occurrence; (b) group or individual medical plans which are certified by the Insurance Commissioner to be equivalent to the required coverage of at least \$1,500; or (c) at least \$1,500 for all such medical and hospital expenses. You may meet this obligation in one of two ways:

Option 1: Private medical insurance. If this option is selected, please provide _____ (Name of Insurer) and _____ (Policy number), _____ (list coverage dates or "continuous"). By signing below, the Adult certifies that the Student is presently covered, and will remain covered during the length of the Team season, under the Policy, and that the Policy complies with Section 32221.

Option 2: Purchase insurance meeting the requirements of Section 32221, for the period during which the Student is participating on the Team, through a coverage provider made available through the District. Please contact the District to gain additional information regarding this program. If you are financially unable to pay for such insurance, a payment waiver can be submitted (waivers are available from the District) and, if no other alternate funding is available through private or charitable organizations, the District will obtain financing for, or provide, the required coverage.

8. Employees, agents or volunteers of the District, members of the press or media, or other persons who may attend or participate in Team Activities, may photograph, videotape, or take statements from the Student. Such photographs, videotapes, recordings, or written statements may be published or reproduced in a manner showing the Student's name, face, likeness, voice, thoughts, beliefs, or appearance to third parties, including, without limitation, webcasts, television, motion pictures, films, newspapers, yearbooks, and magazines. Such published or reproduced items, whether or not for a profit, may be used for security, training, advertising, news, publicity, promotional, informational, or any other lawful purpose. I hereby authorize and consent to any such publications or reproductions, without compensation, and without reservation or limitation.

9. This Agreement shall be governed by the laws of the State of California. This Agreement is to be broadly construed to enforce the purposes and agreements set forth above, and shall not be construed against the Released Parties solely on the basis that this Agreement was drafted by the District. If any part of this Agreement is deemed invalid or ineffective, all other provisions shall remain in force. No oral modification of this Agreement, or alleged change or modification of its terms by subsequent conduct or oral statements, is allowed. This Agreement contains the sole and exclusive understanding of the parties, with no other representation relied upon by the Adult or Student in determining whether to execute this Agreement or in agreeing to participate in Team Activities.

AS THE ADULT SIGNING BELOW: (1) I AM GIVING UP SUBSTANTIAL ACTUAL OR POTENTIAL RIGHTS IN ORDER TO ALLOW THE STUDENT TO PARTICIPATE IN TEAM ACTIVITIES; (2) I HAVE SIGNED THIS AGREEMENT WITHOUT ANY INDUCEMENT OR ASSURANCE OF ANY NATURE, AND WITH FULL APPRECIATION OF THE RISKS INHERENT IN TEAM ACTIVITIES; (3) I HAVE NO QUESTION REGARDING THE SCOPE OR INTENT OF THIS AGREEMENT; (5) I, AS A PARENT OR LEGAL GUARDIAN, HAVE THE RIGHT AND AUTHORITY TO ENTER INTO THIS AGREEMENT, AND TO BIND MYSELF, THE STUDENT, AND ANY AND ANY OTHER FAMILY MEMBER, PERSONAL REPRESENTATIVE, ASSIGN, HEIR, TRUSTEE, OR GUARDIAN TO THE TERMS OF THIS AGREEMENT; (6) I HAVE EXPLAINED THIS AGREEMENT TO THE STUDENT, WHO UNDERSTANDS HIS/HER OBLIGATIONS.

Printed Name of Parent/Guardian Signature Date

As the Student, I understand and agree to all of obligations placed on me by this Agreement.

Printed Name of Student Signature Date



CIF Concussion Information Sheet



Why am I getting this information sheet?

You are receiving this information sheet about concussions because of California state law AB 25 (effective January 1, 2012), now Education Code § 49475:

1. *The law requires a student-athlete who may have a concussion during a practice or game to be removed from the activity for the remainder of the day.*
2. *Any student-athlete removed for this reason must receive a written note from a physician trained in the management of concussion before returning to practice.*
3. *Before a student-athlete can start the season and begin practice in a sport, a concussion information sheet must be signed and returned to the school by the student-athlete and the parent or guardian.*

Every 2 years all coaches are required to receive training about concussions (AB 1451), as well as certification in First Aid training, CPR, and AEDs (life-saving electrical devices that can be used during CPR).

What is a concussion and how would I recognize one?

A concussion is a kind of brain injury. It can be caused by a bump or hit to the head, or by a blow to another part of the body with the force that shakes the head. Concussions can appear in any sport, and can look differently in each person.

Most concussions get better with rest and over 90% of athletes fully recover. However, all concussions should be considered serious. If not recognized and managed the right way, they may result in problems including brain damage and even death.

Most concussions occur without being knocked out. Signs and symptoms of concussion (see back of this page) may show up right after the injury or can take hours to appear. If your child reports any symptoms of concussion or if you notice some symptoms and signs, seek medical evaluation from your team's athletic trainer and a physician trained in the evaluation and management of concussion. If your child is vomiting, has a severe headache, or is having difficulty staying awake or answering simple questions, call 911 for immediate transport to the emergency department of your local hospital.

On the CIF website is a ***Graded Concussion Symptom Checklist***. If your child fills this out after having had a concussion, it helps the physician, athletic trainer or coach understand how they are feeling and hopefully will show improvement over time. You may have your child fill out the checklist at the start of the season even before a concussion has occurred so that we can understand if some symptoms such as headache might be a part of their everyday life. We call this a "baseline" so that we know what symptoms are normal and common for your child. Keep a copy for your records, and turn in the original. If a concussion occurs, your child can fill out this checklist again. This Graded Symptom Checklist provides a list of symptoms to compare over time to follow your child's recovery from the concussion.

What can happen if my child keeps playing with concussion symptoms or returns too soon after getting a concussion?

Athletes with the signs and symptoms of concussion should be removed from play immediately. There is NO same day return to play for a youth with a suspected concussion. Youth athletes may take more time to recover from concussion and are more prone to long-term serious problems from a concussion.

Even though a traditional brain scan (e.g., MRI or CT) may be "normal", the brain has still been injured. Animal and human research studies show that a second blow before the brain has recovered can result in serious damage to the brain. If your athlete suffers another concussion before completely recovering from the first one, this can lead to prolonged recovery (weeks to months), or even to severe brain swelling (Second Impact Syndrome) with devastating consequences.

There is an increasing concern that head impact exposure and recurrent concussions may contribute to long-term neurological problems. One goal of concussion education is to prevent a too early return to play so that serious brain damage can be prevented.



CIF Concussion Information Sheet



Signs observed by teammates, parents and coaches include:

- | | |
|--|--|
| <ul style="list-style-type: none"> • Looks dizzy • Looks spaced out • Confused about plays • Forgets plays • Is unsure of game, score, or opponent • Moves clumsily or awkwardly • Answers questions slowly | <ul style="list-style-type: none"> • Slurred speech • Shows a change in personality or way of acting • Can't recall events before or after the injury • Seizures or "has a fit" • Any change in typical behavior or personality • Passes out |
|--|--|

Symptoms may include one or more of the following:

- | | |
|--|---|
| <ul style="list-style-type: none"> • Headaches • "Pressure in head" • Nausea or throws up • Neck pain • Has trouble standing or walking • Blurred, double, or fuzzy vision • Bothered by light or noise • Feeling sluggish or slowed down • Feeling foggy or groggy • Drowsiness • Change in sleep patterns | <ul style="list-style-type: none"> • Loss of memory • "Don't feel right" • Tired or low energy • Sadness • Nervousness or feeling on edge • Irritability • More emotional • Confused • Concentration or memory problems • Repeating the same question/comment |
|--|---|

What is Return to Learn?

Following a concussion, students may have difficulties with short- and long-term memory, concentration and organization. They will require rest while recovering from injury (e.g., avoid or limit reading, texting, video games, loud movies), or may even need to limit school attendance for a few days. As they return to school, the schedule might need to start with a few classes or a half-day. If recovery from a concussion is taking longer than expected, they may also benefit from a reduced class schedule and/or limited homework; a formal school assessment may also be necessary. Your school or physician can help suggest and make these changes. Students should complete the Return to Learn guidelines and return to complete school before beginning Return to Play, unless your physician makes other recommendations. Go to the CIF website (cifstate.org) for more information on Return to Learn.

How is Return to Play (RTP) determined?

Concussion symptoms should be completely gone before **returning to competition**. A RTP progression is a gradual, step-wise increase in physical effort, sports-specific activities and then finally unrestricted activities. If symptoms occur with activity, the progression should be stopped. If there are no symptoms the next day, exercise can be restarted at the previous stage.

RTP after concussion should occur only with medical clearance from a physician trained in the evaluation and management of concussions, and a step-wise progression program monitored by an athletic trainer, coach, or other identified school administrator. Please see cifstate.org for a graduated return to play plan. [AB 2127, a California state law effective 1/1/15, states that return to play (i.e., full competition) must be **no sooner than 7 days after the concussion diagnosis has been made by a physician.**]

Final Thoughts for Parents and Guardians:

It is well known that students will often not talk about signs of concussions, which is why this information sheet is so important to review with them. Teach your child to tell the coaching staff if they experience such symptoms, or if they suspect that a teammate has had a concussion. You should also feel comfortable talking to the coaches or athletic trainer about possible concussion signs and symptoms that you may be seeing in your child.

References:

- American Medical Society for Sports Medicine position statement: concussion in sport (2013)
- Consensus statement on concussion in sport: the 5th International Conference on Concussion in Sport held in Berlin, October 2016
- <http://www.cdc.gov/concussion/HeadsUp/youth.html>



CIF Concussion Information Sheet



School: _____

You are receiving this information sheet about concussions because of California state law AB 25 (effective January 1, 2012), now Education Code § 49475:

1. *The law requires a student-athlete who may have a concussion during a practice or game to be removed from the activity for the remainder of the day.*
2. *Any student-athlete removed for this reason must receive a written note from a medical doctor trained in the management of concussion before returning to practice.*
3. *Before a student-athlete can start the season and begin practice in a sport, a concussion information sheet must be signed and returned to the school by the student-athlete and the parent or guardian.*

Every 2 years all coaches are required to receive training about concussions (AB 1451), as well as certification in First Aid training, CPR, and AEDs (life-saving electrical devices that can be used during CPR).

For current and up-to-date information on concussions you can visit:
<http://www.cdc.gov/concussion/HeadsUp/youth.html>

I acknowledge that I have received and read the CIF Concussion Information Sheet.

Student-Athlete Name
Printed

Student-Athlete
Signature

Date

Parent or Legal Guardian Name
Printed

Parent or Legal Guardian
Signature

Date

Play It Safe Concussion CareSM



Consent/Release of Information Form

Date: _____

I give my permission for _____
to have a baseline ImpACT test (Immediate Post-concussion Assessment and Cognitive Testing) administered by _____. The ImpACT results may be released to my child's primary care physician or other treating physician as indicated below. They may also release the results to the school's coach, athletic director or trainer, or other representative (i.e. designated concussion coordinator). The test data is stored on a secured server through the ImpACT company which can only be accessed using a valid login and password. This consent is only valid while participating in the current _____ season through _____.

Parent/Guardian: _____

Testing declined

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of doctor: _____

Name of practice or group: _____

Phone number: _____ Fax number: _____

Student's home address: _____

City _____ State _____ Zip _____

Parent or guardian phone numbers (please indicate preferred contact number and time if necessary):

(H) _____ (W) _____ (Cell) _____

Check if it is ok to leave a message