

THIS COMPLETED SPORTS PACKET IS DUE IN NURSE'S OFFICE BEFORE THE FIRST DAY OF TRYOUTS. EACH STUDENT ATHLETE WILL BE REQUIRED TO SUBMIT A NEW SPORTS PACKET EACH ACADEMIC SCHOOL YEAR.

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NORTH HAVEN MIDDLE SCHOOL

55 BAILEY ROAD

NORTH HAVEN, CT 06473

To: Parents/Guardian of Students Playing Interscholastic Sports

From: Athletic Department/Health Service Department

Re: Insurance Coverage for Sports Injuries

The Board of Education carries a plan covering interscholastic sports written on an "excess basis". This means when an injury occurs, the claim must be presented first to your own insurance carrier.

PROCEDURE:

- 1) Students must report all injuries immediately to their coach.
- 2) The coach is to complete the accident report. The coach returns the form to the school nurse's office. Insurance claim is taken home.
- 3) Parent/Guardian submits medical bills to personal insurance carrier first.
- 4) Excess bills not covered by personal insurance carrier must be attached to completed insurance claim and submitted by parent/guardian for payment.

Please do not have medical bills sent directly to the school. This delays your reimbursement process.

Thank you for your cooperation.

Steven Blumenthal
Athletic Director

Revised: 11/2012, 5/2015, 5/2016, 1/2017

**DEPARTMENT OF EDUCATION NORTH
HAVEN, CONNECTICUT**

POLICIES FOR STUDENT PARTICIPATION IN INTERSCHOLASTIC SPORTS

FORMS IN THIS PACKET CONSIST OF:

1. PHYSICAL EXAMINATION:

Form must be completed before tryouts of a sport. This will remain valid for 13 months to date. This physical examination will cover ALL sports played during those 13 months.

2. MEDICATION AUTHORIZATION:

Form must be completed before tryouts of a sport if medication is needed. This authorization will remain valid for one year to date. If a valid medication authorization form is already on file with the school nurse, no additional form is needed.

3. MEDICAL HISTORY:

Medical History Form must be completed and signed by Parent/Guardian and student.

4. PERMISSION SLIP:

Must be signed for each season by the Parent and emergency information must be completed.

5. CODE OF ETHICS:

Must be signed for each season by Parent and Student

6. CONCUSSION CONSENT FORM (*NEW)

Must be signed each school year by the Parent/Guardian and the Student

7. CARDIAC ARREST CONSENT FORM (*NEW)

Must be signed each school year by the Parent/Guardian and the Student

COACHES: **MUST** issue this packet to any student who wishes to participate in a sport.
 MUST distribute insurance information for injuries CIAC rules.
 MUST review eligibility list thoroughly before allowing any athlete to participate in tryouts or practice.

All forms in this packet, including permission, physical, medical history, code of ethics, concussion consent, and cardiac arrest consent, will be reviewed by the school nurse and/or coach. **A new sports packet is required for every school year.** The completed packet must be returned to the school nurse by the player **before the start of tryouts.** The Coach will then receive an eligibility roster and will be notified of any ineligible player. A final roster of medically cleared players will be submitted to the coach on the day of the first practice.

INJURIES:

1. The COACH and INJURED PLAYER must report all injuries to the NURSE the following day.
2. Insurance forms and accident forms are to be completed in duplicate. The school nurse has the forms.
3. **WRITTEN RELEASE:** If the athlete is seen by a health care provider, a written release is required before participation may be resumed.
4. **THE SCHOOL NURSE SHOULD BE INFORMED OF ANY CHANGE IN MEDICAL STATUS OF A POTENTIAL ATHLETE THROUGHOUT THE SCHOOL YEAR.**

NORTH HAVEN MIDDLE SCHOOL
PARENT/GUARDIAN PERMISSION

Student's Name _____ Date of birth _____ Grade _____

Home Address _____ Home Phone _____

Date of most recent physical examination _____

Mother's Name _____ Work Phone _____ Cell _____

Father's Name _____ Work Phone _____ Cell _____

In case of emergency (other than parents):

Name _____ Phone Number(s) _____

Dentist's Name _____ Phone Number _____

Physician's Name _____ Phone Number _____

I/We give our permission for _____ to participate in organized Middle School athletics for the current school year, 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 observance 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 understand that it is my responsibility to report to the school nurse and coach any and all medical or social conditions which may affect the well being of the above designated athlete.

During the academic school year if your son/daughter intends to participate in more than one season, each sport should be circled on this form. Otherwise, additional permission slips will need to be completed and submitted to the nurse.

FALL

Soccer (Boy's)
Soccer (Girl's)
Cross Country (Co-ed)

WINTER

Basketball (Boy's)
Basketball (Girl's)

SPRING

Baseball (Boys)
Softball (Girls)
Track (Co-ed)
Conditioning and weight training
Cheerleading (8th graders only)
*****NOTE: A High School sports packet will be required and will be available Spring 2017**

Parent/Guardian Signature

Date

Student Signature

Part II — Medical Evaluation

HAR-3 REV. 4/2012

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

☐ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

*Height _____ in. / _____ % *Weight _____ lbs. / _____ % BMI _____ / _____ % Pulse _____ *Blood Pressure _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen			*Postural <input type="checkbox"/> No spinal abnormality <input type="checkbox"/> Spine abnormality: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Referral made		
Genitalia/ hernia					
Skin					

Screenings

*Vision Screening			*Auditory Screening			History of Lead level	Date
Type:	Right	Left	Type:	Right	Left	$\geq 5\mu\text{g/dL}$ <input type="checkbox"/> No <input type="checkbox"/> Yes	
With glasses	20/	20/	<input type="checkbox"/> Pass	<input type="checkbox"/> Pass		*HCT/HGB:	
Without glasses	20/	20/	<input type="checkbox"/> Fail	<input type="checkbox"/> Fail		*Speech (school entry only)	
<input type="checkbox"/> Referral made			<input type="checkbox"/> Referral made			Other:	

TB: High-risk group? ☐ No ☐ Yes PPD date read: _____ Results: _____ Treatment: _____

*IMMUNIZATIONS

☐ Up to Date or ☐ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

*Chronic Disease Assessment:

 Asthma ☐ No ☐ Yes: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise induced
 If yes, please provide a copy of the Asthma Action Plan to School
Anaphylaxis ☐ No ☐ Yes: ☐ Food ☐ Insects ☐ Latex ☐ Unknown source

Allergies If yes, please provide a copy of the Emergency Allergy Plan to School

History of Anaphylaxis ☐ No ☐ Yes Epi Pen required ☐ No ☐ YesDiabetes ☐ No ☐ Yes: ☐ Type I ☐ Type II Other Chronic Disease: _____Seizures ☐ No ☐ Yes, type: _____
☐ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
 Explain: _____

Daily Medications (specify): _____

 This student may: ☐ participate fully in the school program
☐ participate in the school program with the following restriction/adaptation: _____

 This student may: ☐ participate fully in athletic activities and competitive sports
☐ participate in athletic activities and competitive sports with the following restriction/adaptation: _____

☐ Yes ☐ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
 Is this the student's medical home? ☐ Yes ☐ No ☐ I would like to discuss information in this report with the school nurse.

Signature of health care provider MD / DO / APRN / PA	Date Signed	Printed/Stamped Provider Name and Phone Number
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NORTH HAVEN MIDDLE SCHOOL

MEDICAL HISTORY

This evaluation is only to determine readiness for sports participation. It does not substitute a doctor's physical exam.

NAME _____ AGE _____ SEX _____ SCHOOL _____

ADDRESS _____ PHONE # _____ GRADE _____

SPORTS BEING PLAYED(1) _____ (2) _____ (3) _____

TO BE COMPLETED BY STUDENT AND PARENT /GUARDIAN

- Do you have any allergies? (Drugs, Food, Insect Stings etc.) _____ Yes _____ No
List: _____
- Are you currently taking any drugs or medications including steroids or protein supplements? _____ Yes _____ No
Explain: _____
- Are you presently being treated for any condition by a physician or other health care professional? _____ Yes _____ No
Explain: _____
- Have you ever been advised by a doctor not to participate in any sport? _____ Yes _____ No
Explain: _____
- Do you have any chronic conditions, disorders or diseases? Check those applicable . . . or _____ NO
 _____ Asthma _____ Bleeding Disorder _____ Diabetes _____ Epilepsy(Seizures) _____ Hepatitis _____ Hypertension
 _____ Sickle Cell Anemia _____ Mononucleosis-Yr _____ Kawasaki's Disease _____ Handicap(Describe) _____ Other(Describe) _____

Please check where applicable if you have or have had any of the following:

	YES	NO		YES	NO
Head injury, concussion, or been unconscious _____ If yes, how many times _____	_____	_____	Eye injury or retinal detachment _____	_____	_____
Headaches more than once a week _____	_____	_____	Blurred vision or vision in one eye only _____	_____	_____
Lack of feeling or numbness in any part of the body _____	_____	_____	Wear glasses or contact lenses _____	_____	_____
Heat exhaustion or heat stroke _____	_____	_____	Hearing loss or impairment in one or both ears _____	_____	_____
Difficulty running 1/2 mile without stopping _____	_____	_____	Tubes in ears or a perforated eardrum _____	_____	_____
Chest pain, dizziness or passing out during exercise _____	_____	_____	False teeth, caps or braces _____	_____	_____
Coughing, wheezing or gasping for breath _____	_____	_____	Nose bleeds for no reason _____	_____	_____
with exercise or cold weather _____	_____	_____	Bruising easily or taking a long time to stop bleeding when cut _____	_____	_____
Smoke cigarettes or chew tobacco _____	_____	_____	Diarrhea more than once a week _____	_____	_____
Heart problem, murmur or arrhythmia _____	_____	_____	Black or bloody bowel movements (stools) _____	_____	_____
Family member with a heart attack under age 50 _____	_____	_____	Kidney disease or dark, brown or bloody urine _____	_____	_____
Loss or gain of more than 10 lbs in last year _____	_____	_____	Less than two kidneys or, in males, two testicles _____	_____	_____
Special diet for medical reasons _____	_____	_____	Lump(s) in arm pit or groin _____	_____	_____
For female participants:			Rash or skin problem _____	_____	_____
Absent or irregular monthly periods _____	_____	_____	Neck, spine or low back injury or pain _____	_____	_____
Disabling cramps with your menstrual periods _____	_____	_____			

Have you ever been hospitalized for medical or surgical reasons? (Circle) YES NO

If yes, provide the following information:

REASON	YEAR	HOSPITAL
_____	_____	_____
_____	_____	_____

Please carefully list below any injury (nerve, muscle, bone or joint) that you have had which did not allow you to participate in regular activity for a week or more?

INJURED AREA (knee, neck, etc.)	YEAR	SIDE (L,R)	TYPE (sprain, swelling)	RESOLVED (Y/N)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PARENT OR GUARDIAN:

I (We) hereby state that I (we) have reviewed this medical history and found the information supplied above to be correct to the best of our knowledge.

Parent/Guardian Signature _____

Date _____

RULES, REGULATIONS, AND GUIDELINES

Eligibility

All students wishing to participate in the Middle School interscholastic program are expected to follow the rules, regulations and guidelines outlined below. In addition, academic eligibility requires student-athletes to maintain at least a C- overall average and must be demonstrating good effort and appropriate social behavior throughout the school and in all classes. Student-athletes who fail any subject are ineligible to participate in any sport. Probationary status may, however, be assigned to students by the coach who will be responsible for monitoring the academic progress of his/her students. Students may stay on probationary status for no more than two weeks, during which time they will need to demonstrate improved behavior and/or academic performance. Academic check sheets may be used for this purpose. In the event that an infraction merits a suspension, the athletic director and coach will confer with the administration. The decision for permanent suspension from a team will be made by the administration.

Team Rules and Regulations

You are a member of a North Haven Middle School Team. This should be viewed as an honor and a privilege. You possess the skills, hustle, and attitude necessary to be a part of this team. As a result, there are certain rules and regulations all members of the team must adhere to. These include, but are not limited to: No swearing, no smoking, no fighting, and no taunting. In addition to any rule or regulation mentioned, it is expected that all players abide by the **NHMS Code of Conduct**, found in the student/parent handbook. As a team, we want to project an image of class. Proper behavior and attitude is essential in this goal. Also, players need to be aware of certain items in the event of disciplinary problems. These are:

-If a player is absent from school the day of a game or a practice, that player will not be able to participate in that day's game or practice unless he or she is in school prior to 11:30 am with a note from a parent or guardian.

-If a player receives a detention, he or she must report to the detention first, and then report to practice.

-If a second detention is received, the player will sit during a game. A third detention (or more) creates a definite problem and will be dealt with accordingly.

-If a player is going to be late for a game or practice, leave early from a game or practice, or will not be able to attend a game or practice, that player should immediately notify the Coach.

-If a player cuts a practice (no excuse or does not give prior notification), the player will sit one game. More than one cut of a practice will be dealt with accordingly.

-If a player cuts a game (no excuse or does not give prior notification), a definite problem has been created. Other disciplinary concerns will be dealt with as the need arises.

Attitude

The coach expects a positive attitude from all players at all times. Players should be eager and willing to attend practice every day with a desire to learn the game in which be or she is participating. This positive attitude should remain throughout games, in school, and at home. This attitude should also reflect the team unity that forms as a result of being a part of a team.

Games

Home games start at approximately 3:30. For away games, the bus will leave promptly at 2:30 (even earlier whenever possible). Directions to away games will be provided.

Practice

Every day after school until approximately 5:00 p.m., unless notified by the coach.

Injuries

-All injuries that occur during a game or practice must be reported immediately to the Coach, then to the school nurse the following day.

-The Coach will submit an accident form to the Nurse.

-Any injury that occurs elsewhere must also be reported to the Coach so he or she has knowledge of it.

-Any injury that is looked at by a healthcare provider requires written clearance from before a player is eligible to begin playing again. The healthcare provider's note must be given to the school nurse, who will notify the coach.

EXPECTATIONS OF THE COACH

The player can expect the Coach to:

- Attend every practice and every game
- Give 110% in every way possible
- Be honest with his or her players
- Provide a positive environment for learning and mastering the game

EXPECTATIONS OF THE PLAYER

The Coach can expect the player to:

- Attend every practice and every game
- Give 110% in every way possible, on the field or floor and in the classroom
- Listen carefully to the Coach's directions and follow them
- Conduct himself/herself in an acceptable manner in school and at all games and practices
- Be respectful of all coaches, officials, parents, and teachers
- Be honest with the Coach

PLAYERS NEVER GIVE UP!

Policy for Parents/Guardians Picking Up Players at the Sites of Away Games

If a player's parent or guardian plans on taking their son or daughter directly home from the site of an away game, the Coach must know about it, in writing, before the game. The player should provide the Coach with a note on the bus or before indicating this plan. In addition, if a player's parent plans on taking another player home, he must receive a written permission from that player's parent.

Also, if a player is going to be late to an away game and will be getting a ride to the site of the away game, the Coach must know about this in writing at least a day before the game.

Cancellation Policy

When there is a game scheduled on a day that has poor weather conditions, all players should listen carefully to the Middle School's afternoon announcements read at 1:55 pm. Any information about the game and/or practices will be included at this time, or hopefully earlier in the day.

MIDDLE SCHOOL CODE OF ETHICS

We have read and understand these guidelines and accept that the athlete's participation in the North Haven Middle School athletic program is dependent upon compliance with the North Haven Middle School Code of Ethics and Code of Conduct.

Student Signature_____ **Date**_____

Parent/Guardian Signature_____ **Date**_____

North Haven Public Schools

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Connecticut State Law and Regulations 10-212(a) require a written medication order of an authorized prescriber, (physician, dentist, optometrist, advanced practice registered nurse or physician's assistant and for interscholastic and intramural athletic events only, a podiatrist) and a parent/guardian's written authorization for the nurse, or in the absence of the nurse, qualified school personnel to administer medication. Medications must be in the original properly labeled container and dispensed by a physician/pharmacist.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____

Address: _____

Condition for which drug is to be administered: _____

Drug Name: _____ Dose: _____ Route: _____

Time of Administration: _____ If PRN, frequency: _____

Relevant side effects: ☐ Not expected ☐ Specify: _____

ALLERGIES: ☐ NO ☐ YES (Specify): _____

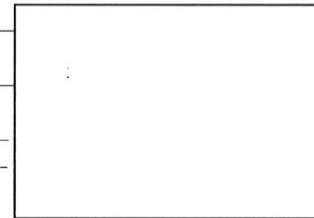
Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____
(Type or Print)

Telephone: _____ Fax: _____

Address: _____

Prescriber's Signature: _____ Date: _____



Use for Prescriber's Stamp

PARENT/GUARDIAN AUTHORIZATION TO ADMINISTER MEDICATION AND FOR THE EXCHANGE OF INFORMATION

Connecticut State Law and Regulations 10-212a-2 require the written permission of the parent/guardian for the exchange of information between the prescriber and the school nurse. I hereby request that the above ordered medication be administered by the school nurse, or qualified school personnel. I understand that I must supply the school with no more than a 3 month supply of medication, and that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first. I also give my consent for the exchange of information between my child's prescriber and the school nurse, if needed, to ensure the safe administration of medication.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Work #: _____ Cell #: _____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION /APPROVAL

Self Administration may be approved by the prescriber, school nurse, and parent/guardian in accordance with Board policy.

Prescriber's Authorization of self administration: ☐ Yes ☐ No _____
Signature Date

Parent/Guardian authorization for self Administration: ☐ Yes ☐ No _____
Signature Date

School nurse approval for self administration: ☐ Yes ☐ No _____
(not required for inhalers or cartridge injectors) Signature Date

North Haven Public Schools

Student & Parent - Concussion Education Plan & Consent Form

NOTE: This document was originally developed to provide coaches with an annual review of current and relevant information regarding concussions and head injuries. A new form is required to be read, signed, and dated and to be kept on file by their associated school district annually to comply with Public Act No. 14—66 AN ACT CONCERNING STUDENT ATHLETES AND CONCUSSIONS. *This NEW form also provides students and parents with the most relevant and current information regarding concussions and head injuries. Per CIAC regulations, all member schools are asked to have this forms signed by each student and their parent / guardian each school year.*

A concussion is the immediate and transient alteration of neurological function in the brain caused by mechanical acceleration and deceleration forces.

Part I – SIGNS AND SYMPTOMS OF A CONCUSSION

- A concussion should be suspected if any one or more of the following signs or symptoms are present, OR if the coach/evaluator is unsure.

1. Signs of a concussion may include (what the athlete looks like):

- Confusion/disorientation/irritability
- Trouble resting/getting comfortable
- Lack of concentration
- Slow response/drowsiness
- Incoherent/ slurred speech
- Slow/clumsy movements
- Loss of consciousness
- Amnesia/memory problems
- Act silly/combatative/aggressive
- Repeatedly ask same questions
- Dazed appearance
- Restless/irritable
- Constant attempts to return to play
- Constant motion
- Disproportionate/inappropriate reactions
- Balance problems

2. Symptoms of a concussion may include (what the athlete reports):

- Headache or dizziness
- Nausea or vomiting
- Blurred or double vision
- Oversensitivity to sound/light/touch
- Ringing in ears
- Feeling foggy or groggy

Note: Public Act No. 14-16 requires that a coach MUST immediately remove a student- athlete from participating in any intramural or interscholastic athletic activity who (A) is observed to exhibit signs, symptoms or behaviors consistent with a concussion following a suspected blow to the head or body, or (B) is diagnosed with a concussion, regardless of when such concussion or head injury may have occurred. **Upon removal of the athlete a qualified school employee must notify the parent or legal guardian within 24 hours that the student has exhibited the signs and symptoms of a concussion.**

Part II – RETURN TO PARTICIPATION (RTP)

Currently, it is impossible to accurately predict how long concussions will last. There must be full recovery before someone is allowed to return to participation. Connecticut Law now requires that no athlete may resume participation until they have received written medical clearance from a licensed health care professional (Physician, Physician Assistant, Advanced Practice Registered Nurse, Athletic Trainer) trained in the evaluation and management of concussions.

Concussion management requirements:

- 1.No athlete SHALL return to participation (RTP) on the same day of concussion.
- 2.Any loss of consciousness, vomiting or seizures the athlete MUST be immediately transported to the hospital.
- 3.Close observation of an athlete MUST continue following a concussion. This should be monitored for an appropriate amount of time following the injury to ensure that there is no escalation of symptoms.
- 4.Any athlete with signs or symptoms related to a concussion MUST be evaluated from a licensed health care professional (Physician, Physician's Assistant, Advanced Practice Registered Nurse, Athletic Trainer) trained in the evaluation and management of concussions.
- 5.The athlete MUST obtain an initial written clearance from one of the licensed health care professionals mentioned above directing them into a well defined RTP stepped protocol similar to one outlined below. If at any time signs or symptoms should return during the RTP progression the athlete should cease activity.
- 6.After the RTP protocol has been successfully administered (no longer exhibits any signs, symptoms or behaviors consistent with concussions), final written medical clearance is required by a licensed health care professional mentioned above, before the student can fully return to unrestricted participation in practices and participation.

Medical Clearance RTP (Return To Play) protocol (Recommended one full day between steps)²

Rehabilitation stage	Functional exercise at each stage of rehabilitation	Objective of each stage
1. No activity	Complete physical and cognitive rest until asymptomatic. School may need to be modified.	Recovery
2. Light aerobic activity	Walking, swimming or stationary cycling keeping intensity, <70% of maximal exertion; no resistance training	Increase Heart Rate
3. Sport Specific Exercise	Skating drills in ice hockey, running drills in soccer; no head impact activities	Add Movement
4. Non-contact Training drills	Progression to more complex training drills, ie. passing drills in football and ice hockey; may start progressive resistance training	Exercise, coordination and cognitive load
5. Full Contact Practice	Following final medical clearance, participate in normal training activities	Restore confidence and assess functional skills by coaching staff

* If at any time signs or symptoms should worsen during the RTP progression the athlete should stop activity that day. If the athlete's symptoms are gone the next day, s/he may resume the RTP progression at the last step completed in which no symptoms were present. If symptoms return and don't resolve, the athlete should be referred back to their medical provider.

Part III - HEAD INJURIES

– Injuries to the head includes:

- Concussions: (See above information). There are several head injuries associated with concussions which can be severe in nature including:
 - a) Second impact Syndrome - Athletes who sustain a concussion, and return to play prior to being recovered from the concussion, are also at risk for Second Impact Syndrome (SIS), a rare but life-altering condition that can result in rapid brain swelling, permanent brain damage or death; and
 - b) Post Concussion Syndrome - A group of physical, cognitive, and emotional problems that can persist for weeks, months, or indefinitely after a concussion.
- Scalp Injury: Most head injuries only damage the scalp (a cut, scrape, bruise or swelling)... Big lumps (bruises) can occur with minor injuries because there is a large blood supply to the scalp. For the same reason, small cuts on the head may bleed a lot. Bruises on the forehead sometimes cause black eyes 1 to 3 days later because the blood spreads downward by gravity;
- Skull Fracture: Only 1% to 2% of children with head injuries will get a skull fracture. Usually there are no other symptoms except for a headache at the site where the head was hit. Most skull fractures occur without any injury to the brain and they heal easily;

Brain Injuries are rare but are recognized by the presence of the following symptoms:

(1) difficult to awaken, or keep awake or (2) confused thinking and talking, or (3) slurred speech, or (4) weakness of arms or legs or (5) unsteady walking”(American Academy of Pediatrics – Healthy Children, 2010) .

I have read and understand this document the “Student/Parent - Concussion Education Plan & Consent Form” and understand the severities associated with concussions and the need for immediate treatment of such injuries.

Student name: _____ Date _____ Signature: _____
(Print Name)

Parent name: _____ Date _____ Signature _____
(Print Name)

References:

NFHS. Concussions. 2008 NFHS Sports Medicine Handbook (Third Edition). 2008: 77-82.

<http://www.nfhs.org>.

McCrory, Paul MBBS, PhD; Meeuwisse, Willem MD, PhD; Johnston, Karen MD, PhD; Dvorak, Jiri MD; Aubry, Mark MD; Molloy, Mick MB; Cantu, Robert MA, MD. Consensus Statement on Concussion in Sport 3rd International Conference on Concussion in Sport Held in Zurich, November 2008. Clinical Journal of Sport Medicine: May 2009 - Volume 19 - Issue 3 - pp 185-200

http://journals.lww.com/cjsportsmed/Fulltext/2009/05000/Consensus_Statement_on_Concussion_in_Sport_3rd.1.aspx

Centers for Disease Control and Prevention. *Heads Up: Concussion in High School Sports*. http://www.cdc.gov/NCIPC/tbi/Coaches_Tool_Kit.htm

U.S. Department of Health and Human Services Centers For Disease Control and Prevention. *A Fact Sheet for Coaches*. (2009). Retrieved on June 16, 2010.

http://www.cdc.gov/concussion/pdf/coaches_Engl.pdf

American Academy of Pediatrics - Healthychildren. *Symptom check: Head Injury*. Retrieved on June 16, 2010.

<http://www.healthychildren.org/english/tips-tools/symptom-checker/pages/Head-Injury.aspx>

Resources:

Centers for Disease Control and Prevention. *Injury Prevention & Control: Traumatic Brain Injury*. Retrieved on June 16, 2010.

<http://www.cdc.gov/TraumaticBrainInjury/index.html>

Centers for Disease Control and Prevention. *Heads Up: Concussion in High School Sports Guide for Coaches*. Retrieved on June 16, 2010

North Haven Public Schools
Student & Parent – Sudden Cardiac Arrest Plan & Consent Form

NOTE: This document was developed to provide coaches with an annual review of current and relevant information regarding sudden cardiac arrest. A new form is required to be read, signed, dated and kept on file by their associated school district annually to comply with Public Act No. 14—93 AN ACT CONCERNING SUDDEN CARDIAC ARREST PREVENTION

PART I – SUDDEN CARDIAC ARREST - What is sudden cardiac arrest? Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens, blood stops flowing to the brain and other vital organs. SCA doesn't just happen to adults; it takes the lives of students, too. However, the causes of sudden cardiac arrest in students and adults can be different. A student's SCA will likely result from an inherited condition, while an adult's SCA may be caused by either inherited or lifestyle issues. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

PART II - HOW COMMON IS SUDDEN CARDIAC ARREST IN THE UNITED STATES? SCA is the #1 cause of death for adults in this country. There are about 300,000 cardiac arrests outside hospitals each year. It is the #1 cause of death for student athletes.

PART III - WHAT ARE THE WARNING SIGNS AND SYMPTOMS? Although SCA happens unexpectedly, some people may have signs or symptoms, such as: fainting or seizures during exercise; unexplained shortness of breath; dizziness; extreme fatigue; chest pains; or racing heart. These symptoms can be unclear in athletes, since people often confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

PART IV - WHAT ARE THE RISKS OF PRACTICING OR PLAYING AFTER EXPERIENCING THESE SYMPTOMS? There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who experience SCA die from it.

PART V - REMOVAL FROM PLAY Any student-athlete who shows signs or symptoms of SCA must be removed from athletic activity and referred to a licensed health care profession trained specifically in the treatment of cardiac care. The symptoms can happen before, during or after activity.

PART VI - RETURN TO PLAY Before returning to play, the athlete must be evaluated. Clearance to return to play must be in writing. The evaluation must be performed by a licensed medical provider.

I have read and understand this document and understand the law requires me to annually review this Connecticut State Department of Education Approved Sudden Cardiac Arrest Educational Plan. I have read and understand this document the "Student & Parent – Sudden Cardiac Arrest Plan & Consent Form" and understand the severities associated with sudden cardiac arrest and the need for immediate treatment of any suspected condition.

Parent name (Please Print): _____ **Date** _____

Parent Signature _____

Simons Fund - <http://www.simonsfund.org/>

Pennsylvania Department of Health - <http://www.simonsfund.org/wp-content/uploads/2012/06/Parent-Handout-SCA.pdf>