

## Richland School District One Required Sports Forms

Please use these instructions as a guide for filling out the required forms for athletes to participate on athletic teams in Richland School District One. These forms will need to be filled out on a yearly basis and each child must turn in their own individual forms.

1. **Physical form** – The front of this form is to be filled out completely by both the student-athlete and the parent/legal guardian PRIOR to seeing a physician. The back side of the form is to be completed by a physician once the exam has been completed.
2. **Richland One Sports Health Form** – This form is to be read and completed in full by the parent/guardian of the student-athlete. This information assists the sports medicine team in providing the best possible health care for the student-athlete. This form also contains the consent to participate and risk waiver.
3. **Concussion Statement** – This form is to be read and completed AFTER reading the Concussion Information Sheet provided with this packet. This statement serves as documentation of receipt of information regarding concussions and upholds SC Bill H3601.
4. **Concussion Information Sheet** – This sheet is to be read and kept by the student-athlete and parent for future reference. This sheet provides information on concussions and the risk associated with return to sport after sustaining a concussion.



# RICHLAND SCHOOL DISTRICT ONE

## CONCUSSION INFORMATION SHEET FOR STUDENT-ATHLETES & PARENTS/LEGAL GUARDIANS

**SC Bill H3601:** South Carolina State Law requires all SCHSL athletes and their parents/legal guardians to be given an information sheet on concussions which informs of the nature and risk of concussion and brain injury and the risks of returning to play after sustaining a head injury. This document serves as an informational sheet to be kept by the parents or guardians for future referral.

**What is a concussion?** A concussion is an injury to the brain caused by a direct or indirect blow to the head. It results in your brain not working as it should. It may or may not cause you to black out or pass out. It can happen to you from a fall, a hit to the head, or a hit to the body that causes your head and your brain to move quickly back and forth.

**How do I know if I have a concussion?** There are many signs and symptoms that you may have following a concussion. A concussion can affect your thinking, the way your body feels, your mood, or your sleep. Here is what to look for:

Thinking / Remembering	Physical	Emotional/Mood	Sleep
Difficulty thinking clearly	Headache	Irritability-things bother you more easily	Sleeping more than usual
Taking longer to figure things out	Fuzzy or blurry vision	Sadness	Sleeping less than usual
Difficulty concentrating	Feeling sick to your stomach/queasy	Being more moody	Trouble falling asleep
Difficulty remembering new information	Vomiting/throwing up	Feeling nervous or worried	Feeling tired
	Dizziness	Crying more	
	Balance problems		
	Sensitivity to noise or light		

Table is adapted from the Centers for Disease Control and Prevention (<http://www.cdc.gov/concussion/>)

**What should I do if I think I have a concussion?** If you are having any of the signs or symptoms listed above, you should tell your parents, coach, athletic trainer or school nurse so they can get you the help you need. If a parent notices these symptoms, they should inform the school nurse or athletic trainer.

**When should I be particularly concerned?** If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, or your words are coming out funny/slurred, you should let an adult like your parent or coach or teacher know right away, so they can get you the help you need before things get any worse.

**What are some of the problems that may affect me after a concussion?** You may have trouble in some of your classes at school or even with activities at home. If you continue to play or return to play too early with a concussion, you may have long term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur once you have a concussion, you are more likely to have another concussion.

**How do I know when it's ok to return to physical activity and my sport after a concussion?** After telling your coach, your parents, and any medical personnel around that you think you have a concussion, you will probably be seen by a doctor trained in helping people with concussions. Your school and your parents can help you decide who is best to treat you and help to make the decision on when you should return to activity/play or practice. Your school will have a policy in place for how to treat concussions. You should not return to play or practice on the same day as your suspected concussion.

**You should not have any symptoms at rest or during/after activity when you return to play, as this is a sign your brain has not recovered from the injury.**

**This sheet is for your records and personal use, please retain.**



# Richland School District One Sports Health Form

## EMERGENCY CONTACT INFORMATION

(Please Print)

Athlete's Name \_\_\_\_\_ School \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ School Year \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Name \_\_\_\_\_ Phone # \_\_\_\_\_ Cell/Business # \_\_\_\_\_ Email \_\_\_\_\_

Father's Name \_\_\_\_\_ Phone # \_\_\_\_\_ Cell/Business # \_\_\_\_\_ Email \_\_\_\_\_

*In an EMERGENCY, if parents cannot be contacted notify:*

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Cell/Business #: \_\_\_\_\_ Relationship \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone # \_\_\_\_\_ Family Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

## HEALTH INSURANCE INFORMATION

\*Do you have health insurance? Y / N \_\_\_\_\_ Do you have Medicaid? Y / N \_\_\_\_\_ Medicaid Number \_\_\_\_\_

Name of Company \_\_\_\_\_ Mailing Address \_\_\_\_\_

Insured's Name \_\_\_\_\_ Policy # \_\_\_\_\_

**\*Richland School District One School Board Policy JLA – Student Insurance Coverage requires that all students participating in athletics and/or auxiliary sports-support related activities purchase accident insurance provided through the school district. Richland School District 1 carries athletic accident insurance on all its athletes, intended to be an “excess” policy designed to pay secondarily to the athlete’s primary health insurance. In the event of injury, while participating as a part of a SCHSL sanctioned sports team representing Richland One, the athlete should seek the attention of the sports medicine staff as soon as possible. The athletic trainer (high school) or school official (middle school) will fill out the top portion of the insurance claim form (aka Notification of Injury Form). The parent/guardian should complete the claim form, follow the attached directions, and mail the completed form to the insurance company. \*Please note the claim must be filed within 90 days of injury.\***

*I understand this information and will notify the head athletic trainer prior to the doctor’s appointment if I require a claim form for an injury that meets the above requirements.*

Parent's Signature \_\_\_\_\_

Date \_\_\_\_\_

## CONSENT FOR MEDICAL TREATMENT/RELEASE OF INFORMATION

I/We give consent for certified athletic trainers, coaches, and physicians to use their own judgment in securing medical aid and ambulance service in the case the parents/guardians cannot be reached. In the event of an accident requiring immediate medical attention, I hereby grant permission to physicians, certified athletic trainers, and/or appropriate healthcare professionals to attend to my son/daughter. It is understood that the school cannot be held responsible for any medical bills incurred because of illness or injury. Furthermore, I/We give permission for our son/ daughter to be evaluated and treated by the school’s certified athletic training staff and/or team physicians if he/she becomes injured while participating as an athlete in Richland One during the school year. I/We also authorize the school’s sports medicine staff to be given medical information concerning my son/daughter by a physician or their staff. Likewise, the school’s sports medicine staff may release medical information to physician’s offices, coaching staff, nurses, administrators and faculty within Richland One as they see appropriate. I also commit to reporting ALL injuries to the Sports Medicine Staff, including but not limited to any symptoms related to a concussion. I also understand that the sports medicine staff will follow a return to play protocol for all injuries.

## CONSENT TO PARTICIPATE IN ATHLETICS AND RISK WAIVER

As the parent or legal guardian of the above named student-athlete, I give my permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular healthcare. I grant permission to nurses, certified athletic trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means.

Student's Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent's Signature \_\_\_\_\_

Date \_\_\_\_\_

*A photocopy of this document shall serve as good as original.*



# **RICHLAND SCHOOL DISTRICT ONE**

## **Student-Athlete & Parent/Legal Guardian Concussion Statement**

*\*If there is anything on this sheet that you do not understand, please ask a school staff member to explain it to you.*

*\*This form must be completed for each student –athlete, even if there are multiple student-athletes in each household.*

Student-Athlete Name: \_\_\_\_\_

Parent/Legal Guardian Name(s): \_\_\_\_\_

- ☐ We have read the *Student-Athlete & Parent/Legal Guardian Concussion Information Sheet*.  
If true, please check box.

After reading the information sheet, I am aware of the following information:

Student-Athlete Initials		Parent/Legal Guardian Initials
	A concussion is a brain injury, which should be reported to my parents, my coach(es), athletic trainer, or a medical professional if one is available.	
	A concussion can affect the ability to perform everyday activities such as the ability to think, balance, and classroom performance.	
	A concussion cannot be “seen.” Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.	
	I will tell my parents, my coach, athletic trainer, and/or a medical professional about my injuries and illnesses.	N/A
	If I think a teammate has a concussion, I should tell my coach(es), parents, athletic trainer or medical professional about the concussion.	N/A
	I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.	N/A
	I will/my child will need written permission from a physician to return to play or practice after a concussion.	
	Based on the latest data, most concussions take days or weeks to get better. A concussion may not go away right away. I realize that resolution from this injury is a process and may require more than one medical evaluation.	
	I realize that ER/Urgent Care physicians will not provide clearance for return to play from this injury on the day they are injured.	
	After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before concussion symptoms go away.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I understand that I will have to complete a graduated return to play and have written permission from a physician before I will be able to return to my sport per the school’s concussion management policy.	
	I have read and received the concussion symptoms on the Concussion Information Sheet.	

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

**PLEASE RETURN THIS COMPLETED FORM TO THE SCHOOL’S ATHLETIC DEPARTMENT**



# PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines

☐ Pollens

☐ Food

☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

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\_\_\_\_\_

\_\_\_\_\_

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

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# PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

## PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
  - Do you feel stressed out or under a lot of pressure?
  - Do you ever feel sad, hopeless, depressed, or anxious?
  - Do you feel safe at your home or residence?
  - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
  - During the past 30 days, did you use chewing tobacco, snuff, or dip?
  - Do you drink alcohol or use any other drugs?
  - Have you ever taken anabolic steroids or used any other performance supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP / ( / )	Pulse	Vision R 20/	L 20/
		Corrected <input type="checkbox"/> Y <input type="checkbox"/> N	
<b>MEDICAL</b>	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>	
Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</li> </ul>			
Eyes/ears/nose/throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>			
Lymph nodes			
Heart* <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, supine, +/- Valsalva)</li> <li>Location of point of maximal impulse (PMI)</li> </ul>			
Pulses <ul style="list-style-type: none"> <li>Simultaneous femoral and radial pulses</li> </ul>			
Lungs			
Abdomen			
Genitourinary (males only) <sup>b</sup>			
Skin <ul style="list-style-type: none"> <li>HSV, lesions suggestive of MRSA, tinea corporis</li> </ul>			
Neurologic <sup>c</sup>			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional <ul style="list-style-type: none"> <li>Duck-walk, single leg hop</li> </ul>			

\*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.

<sup>c</sup>Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- ☐ Cleared for all sports without restriction
- ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_
- ☐ Not cleared
- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports \_\_\_\_\_
- Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

## Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

Name (please print) \_\_\_\_\_

As a parent or legal guardian of the above named student-athlete. I give permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

Signature of Athlete \_\_\_\_\_

\_\_\_\_\_  
Date

Signature of Parent/Guardian \_\_\_\_\_

\_\_\_\_\_  
Date

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