Germantown High School Athletics
Medical Packet Checklist

Please ensure you have the following completed properly:

- Pre-Participation Form (Pg 1)
- Copies of Insurance Card (Pg2)
- Informed Consent/Assumption of Risk Form (Pg3)
- Medical History Form (Pg 4)*
- Physical Examination Form (Pg 5)**
- Consent for Medical Treatment (Pg 6)
- Authorization for Release of Information (Pg 7)
- Sudden Cardiac Arrest Acknowledgment Form (Pg 8 & Pg 9)
- Concussion Statement and Acknowledgement Form (Pg 10)
  Pages 11 & 12 are for the family to keep for future reference.

NOTE: Only completed packets will be accepted. Do **NOT** turn in individual pages or an incomplete packet for they will be returned with your child.

* Medical history form must be fully completed and signed by both parents and the student-athlete. If you check "YES" to any box, you must explain why at the bottom of the form.

** The Physical Examination form is the TSSAA standard and must be fully completed. Physical forms from other providers will not be accepted in lieu of this form.

--ALL COMPLETED PACKETS MUST TO TURNED INTO "M" OFFICE--

Any questions or concerns regarding this paperwork should be directed to:

Joseph Pettitt, LAT, ATC
Certified Athletic Trainer
(901) 482-2966
jpettitt@orthomemphis.com

GERMANTOWN

ORTHOMEMPHIS
SPORTS MEDICINE
A Division of MSK Group, P.C.

School Sports Pre-Participation Physical
2017-2018

ATHLETE INFORMATION			
Name *(Last, First, M.I.):*		**Birthdate:**	**Sex**: ☐ M ☐ F
Sport:	☐ Football ☐ Basketball ☐ Soccer ☐ Baseball ☐ Softball ☐ Wrestling ☐ Volleyball ☐ Track ☐ Other: _____		

MERGENCY CONTACT INFORMATION

Name *(Last, First, M.I.):*		**Relationship:**
Street Address:	**City, State, Zip:**	
E-mail:		**Phone:**
Is this the student-athlete's current residence? Yes No		
Name *(Last, First, M.I.):* ☐ ☐		**Relationship:**
Street Address:	**City, State, Zip:**	
E-mail:		**Phone:**
Is this the student-athlete's current residence? Yes No		
☐ ☐		

Athlete and Parent/Guardian Consent:
I consent to participation in my sports program, including practice sessions and travel to and from athletic contests. If my medical status changes in any significant manner after I pass the physical examination, I will notify the sports program immediately. I also consent to the use of the data collected in the health questionnaire for research purposes, the results of which will be restricted to sports participation health risk assessment. Release of any information for research purposes, including published results, will not in any way identify me.

Athlete Signature: _____Date:_____

Parent/Guardian Signature:_____Date:_____

TSSAA Legal Parental Consent:
I/We hereby give consent for (athlete's name) _____to represent (name of school)_____ in athletics realizing that such activity involves potential for injury. I/We acknowledge that even with the best coaching, the most advanced equipment, and strict observation of the rules, injuries are still possible. ***On rare occasions these injuries are severe and result in disability, paralysis, and even death. I/We further grant permission to the school and TSSAA, its physicians, Athletic Trainers, and/or EMT(s) to render aid, treatment, medical, or surgical care deemed reasonably necessary to the health and wellbeing of the student-athlete named above during or resulting from participation in athletics***. By the execution of this consent, the student-athlete named above and his/her parent/guardian(s) do hereby consent to screening, examination, and testing of the student-athlete during the course of the pre-participation examination by those performing the evaluation, and to the taking of medical history information and the recording of that history and the findings and comments pertaining to the student-athlete on the forms attached hereto by those practitioners performing the examination. As parent or legal Guardian, ***I/We remain fully responsible for any legal responsibility which may result from any personal actions taken by the above named student-athlete.***

It is also the sole responsibility of the student-athletes parent/guardian to have and carry and continue to carry medical insurance for the student-athlete to participate in athletics at said school.

Athlete Signature: _____Date:_____

Parent/Guardian Signature:_____Date:_____

Please include a Front & Back Copy of your insurance card

-OR-

Complete the following information

Insurance Company:_____

Policy #: _____

Group #: _____

Informed Consent and Assumption of Risk Form

NOTE: This form must be completed by all students, regardless of grade, intending to participate in any sport. All minor students must sign and have a parent or legal guardian also sign. **All forms are to be completed and returned to the appropriate sport representative prior to tryout.** Failure of a school to provide a duly executed form will cause the student-athlete to be declared ineligible.

The undersigned, being an adult prospective student-athlete (sometimes referred to herein as "student") or parent/legal guardian of the undersigned minor prospective student-athlete, hereby acknowledges that said student-athlete seeks to participate in a student sports program during the _____ academic school year. The undersigned specifically asserts that the student will comply with all rules and regulations; that s/he is aware that athletic participation requires physical fitness; that the student possesses such fitness; and that some risk of serious injury and even death is involved in sports participation. The undersigned hereby authorizes the release of information and reports concerning the academic standing, medical condition, financial aid, attendance, residency, and disciplinary record of the undersigned student to the above-selected association for the purpose of rule and regulations\ enforcement. I further authorize the school (or its designee) to provide and perform emergency treatment of any injury or illness the student-athlete may experience if qualified medical personnel consider treatment necessary. I understand that authorization is granted only if I cannot be reached, or the undersigned is under an immediate and imminent threat of permanent debilitation or death.

By providing my initials here, the undersigned acknowledges that s/he has read and understands the following WARNING: Do not use any helmet to butt, ram or spear an opposing player. This can result in severe head, brain or neck injury, paralysis or death to you and possible injury to your opponent. There is a risk these injuries may also occur as a result of accidental contact without intent to butt, ram or spear. NO HELMET CAN PREVENT ALL SUCH INJURIES.

_____

(Initials Here)

The undersigned further acknowledges that s/he is aware that participating in sports is a potentially hazardous activity, and that s/he, therefore, assumes all risks associated with participation in the sport in which s/he has selected to participate, including, but not limited to falls, physical and potentially injurious or fatal contact with other participants, the effects that weather may have on the playing conditions of the sport, traffic, and other reasonable risk conditions associated with the sport. The undersigned acknowledges, appreciates and understands all such risks, and agrees to the conditions set forth in this form.

Student's Signature	_____	**Date**	_____
Parent's Signature	_____	**Date**	_____
(if student is under the age of 18)			

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

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: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ 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: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ 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

_____

_____

_____

_____

_____

_____

_____

_____

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 _____

HE0503 9-2681/0410

Preparticipation Physical Evaluation
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. 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?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]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

HE0503 9-2681/0410

CONSENT FOR MEDICAL TREATMENT
MSK Group, P.C. on Behalf of (the "School")

This authorization/consent will allow MSK Group, P.C. ("MSK") health care providers to facilitate drug testing of all students on behalf of the School and also to provide students with medical services and treatment on behalf of the School as set forth below.

Consent for Medical Treatment

I _____(please print student's name) hereby authorize MSK, its Athletic Trainers, employees and staff (or their designee) to render any and all medical evaluation and/or treatment, including without limitation, the use of necessary x-rays, injections, casting, bracing, or other diagnostic tests, during my participation in activities with the School or due to any injury that I may sustain while on School premises or incurred during my participation in School-related events. I further authorize MSK, its Athletic Trainers, employees and staff (or their designee) to render any necessary follow-up medical evaluation and/or treatment, including without limitation, the use of x-rays, injections, casting, bracing or other diagnostic tests, performed at MSK or any of its affiliated clinics.

School Name: _____

SIGNATURE OF STUDENT:

Expiration: This consent will expire upon the later of the student's graduation or the completion of the student's participation in School-related events.

Signatures: All students must sign this consent. If the student is under 18 years of age at the time of signature, a parent or legal guardian must sign this authorization/consent as well. By signing this consent, the student understands that it will continue to be in effect upon the student turning 18 years of age.

I, _____, parent and/or legal guardian of _____, student, acknowledge that I am authorized to provide my consent and by signing this form provide my authorization and consent for the drug testing and medical treatment of the above named student for the limited purposes described above.

Parent/Guardian Signature : _____ DATE: _____

Please Print Signatory's Name:_____

Address: _____

Relationship to Student (if Student is under 18 years of age): _____

Student's Signature: _____

Please Print Student's Name: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

This authorization for release of protected health information is provided by MSK Group, P.C. ("MSK"). Please see the Patient Notice for information regarding how your medical information may be used or disclosed.. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of the Notice from the Compliance Officer of MSK. The Notice is also posted at MSK offices and on the MSK website.

- **YOU HAVE THE RIGHT TO INSPECT, COPY AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.**
- **YOU MAY REFUSE TO SIGN THIS FORM, HOWEVER IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED .**
- **WE WILL NOT CONDITION YOUR TREATMENT ON THIS AUTHORIZATION.**
- **WE WILL PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.**

THIS AUTHORIZATION IS VOLUNTARY

TO BE COMPLETED BY STUDENT OR PARENT/LEGAL GUARDIANCE

I, (Print Student's Name)_____, Date of Birth _____
do hereby authorize MSK to obtain, use, disclose or receive my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that information released under this authorization may be redisclosed by the recipient of the information and may no longer be protected by state and federal law.

I hereby authorize MSK to release my medical information and related information regarding my physical condition or regarding any injury, illness or condition that I sustain due to my involvement in activities at my school, _____to a coach, team member, administrative staff of my school, family member or legal guardian for purposes of enhancing my safety in connection with my participation or presence at school-related activities and to establish open lines of communication regarding my medical condition and status. I understand this information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information.

I understand that I may withdraw my authorization in writing to the Compliance Officer of MSK at any time, except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire **upon the later date of my graduation or the completion of my participation in school-related events.** I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Signatures: All students must sign this consent. If the student is under 18 years of age at the time of signature, a parent or legal guardian must sign this authorization as well. By signing this authorization, the student understands that it will continue to be in effect upon the student turning 18 years of age.

I, _____, parent and/or legal guardian of _____, student, acknowledge that I am authorized to provide my consent and by signing this form provide my authorization and consent for the release of protected health information of the above named student for the limited purposes described above.

Parent/ Guardian Signature :_____ DATE: _____

Please Print Signatory's Name:_____

Address: _____

Relationship to Student (if Student is under 18 years of age): _____

Student's Signature: _____

Please Print Student's Name: _____

Athlete/Parent/Guardian Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form

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 youth athlete'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.

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. About 2,000 patients under 25 die of SCA each year. It is the #1 cause of death for student athletes.

Are there warning signs?
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.

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.

Public Chapter 325 – the Sudden Cardiac Arrest Prevention Act
The act is intended to keep youth athletes safe while practicing or playing. The requirements of the act are:

- All youth athletes and their parents or guardians must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.

Adapted from PA Department of Health: Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form. 7/2013

- The immediate removal of any youth athlete who passes out or faints while participating in an athletic activity, or who exhibits any of the following symptoms:
  (i) Unexplained shortness of breath;
  (ii) Chest pains;
  (iii) Dizziness
  (iv) Racing heart rate; or
  (v) Extreme fatigue; and

- Establish as policy that a youth athlete who has been removed from play shall not return to the practice or competition during which the youth athlete experienced symptoms consistent with sudden cardiac arrest

- Before returning to practice or play in an athletic activity, the athlete must be evaluated by a Tennessee licensed medical doctor or an osteopathic physician. Clearance to full or graduated return to practice or play must be in writing.

I have reviewed and understand the symptoms and warning signs of SCA.

Signature of Student-Athlete Print Student-Athlete's Name Date

_____ _____ _____

Signature of Parent/Guardian Print Parent/Guardian's Name Date

Student-Athlete & Parent/Legal Guardian Concussion Statement

Must be **signed and returned** to school or community youth athletic activity prior to participation in practice or play.

Student-Athlete Name: _____

Parent/Legal Guardian Name(s): _____

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, coach(es) or a medical professional if one is available.	
	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 and/or a medical professional about my injuries and illnesses.	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 *health care provider** to return to play or practice after a concussion.	
	Most concussions take days or weeks to get better. A more serious concussion can last for months or longer.	
	After a bump, blow, or jolt to the head or body an athlete should receive immediate medical attention if there are any danger signs such as loss of consciousness, repeated vomiting or a headache that gets worse.	
	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 the concussion symptoms go away.	
	Sometimes repeat concussions can cause serious and long-lasting problems and even death.	
	I have read the concussion symptoms on the Concussion Information Sheet.	

**Health care provider means a Tennessee licensed medical doctor, osteopathic physician, or a clinical neuropsychologist with concussion training.*

_____ _____

Signature of Student-Athlete Date

_____ _____

Signature of Parent/Legal Guardian Date

PLEASE KEEP THIS PAGE FOR REFERENCE

CONCUSSION

INFORMATION AND SIGNATURE FORM
FOR STUDENT-ATHLETES & PARENTS/LEGAL GUARDIANS

(Adapted from CDC "Head's Up Concussion in Youth Sports")

Public Chapter 148, effective January 1, 2014, requires that school and community organizations sponsoring youth athletic activities establish guidelines to inform and educate coaches, youth athletes and other adults involved in youth athletics about the nature, risk, and symptoms of concussion/head injury.

Read and keep this page.
Sign and return the signature page.

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move rapidly back and forth. Even a "ding", "getting your bell rung" or what seems to be a mild bump or blow to the head can be serious.

Did you know?

- Most concussions occur *without* the loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports **one or more** symptoms of concussion listed below after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury and until a health care provider* says s/he is symptom-free and it's OK to return to play.

SIGNS OBSERVED BY COACHING STAFF	SYMTPOMS REPORTED BY ATHLETES
Appears dazed or stunned	**Headache or "pressure" in head**
Is confused about assignment or position	**Nausea or vomiting**
Forgets an instruction	**Balance problems or dizziness**
Is unsure of game, score, or opponent	**Double or blurry vision**
Moves clumsily	**Sensitivity to light**
Answers questions slowly	**Sensitivity to noise**
Loses consciousness, even briefly	**Feeling sluggish, hazy, foggy, or groggy**
Shows mood, behavior or personality changes	**Concentration or memory problems**
Can't recall events prior to hit or fall	**Confusion**
Can't recall events after hit or fall	**Just not "feeling right" or "feeling down"**

PLEASE KEEP THIS PAGE FOR REFERENCE

CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention after a bump, blow, or jolt to the head or body if s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that not only does not diminish, but gets worse
- Weakness, numbness or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless or agitated
- Has unusual behavior
- Loses consciousness *(even a brief loss of consciousness should be taken seriously)*

WHY SHOULD AN AHTLETE REPORT HIS OR HER SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brains. *They can even be fatal.*

Remember:
Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care provider* says s/he is symptom-free and it's OK to return to play.

Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration such as studying, working on the computer or playing video games may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

**Health care provider means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training.*