MHSA CONFIDENTIAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION

See Montana High School Association, Article II, Section (3), Physical Exam. A physical examination is required for each student in order to be considered eligible for participation in an Association contest. Physical examinations must be completed prior to the first practice. This examination must be certified by a licensed medical professional acting within the scope and limitations of his/her practice. This certification is valid for a period of one school year. **A physical examination conducted before May 1st is not valid for participation for the following school year. All information is to remain confidential.**

HISTORY – To be completed by the student and parent(s).

QUESTIONNAIRE FOR ATHLETIC PARTICIPATION (PLEASE PRINT)

Name _____ Male ☐ Female ☐ Grade _____ Date of Birth _____

Home Address _____ Phone Number _____

Parent's Name _____ Family Physician _____

Current School _____ Date _____

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

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Are you taking medicine for ADHD?	☐	☐
5. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
6. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
7. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
8. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
9. Does your heart race or skip beats during exercise?	☐	☐
10. Has a doctor ever told you that you have (circle all that apply): High blood pressure / A heart murmur / High cholesterol / A heart infection		
11. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram)	☐	☐
12. Has anyone in your family died for no apparent reason?	☐	☐
13. Does anyone in your family have a heart problem?	☐	☐
14. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
15. Does anyone in your family have Marfan syndrome?	☐	☐
16. Have you ever spent the night in a hospital?	☐	☐
17. Have you ever had surgery?	☐	☐
18. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game: If yes, circle affected area below:	☐	☐
19. Have you had any broken or fractured bones, or dislocated joints? If yes, circle below:	☐	☐
20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand / fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot / toes

21. Have you ever had a stress fracture?	☐	☐
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
23. Do you regularly use a brace or assistive device?	☐	☐
24. Has a doctor ever told you that you have asthma or allergies?	☐	☐
25. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
26. Is there anyone in your family who has asthma?	☐	☐
27. Have you ever used an inhaler or taken asthma medicine?	☐	☐
28. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
29. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
30. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
31. Have you had a herpes skin infection?	☐	☐
32. Have you ever had a head injury or concussion?	☐	☐
33. Have you been hit in the head and been confused or lost your memory?	☐	☐
34. Have you ever had a seizure?	☐	☐
35. Do you have headaches with exercise?	☐	☐
36. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
37. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
38. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
39. Has a doctor told you that your or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
40. Have you had any problems with your eyes or vision?	☐	☐
41. Do you wear glasses or contact lenses?	☐	☐
42. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
43. Are you happy with your weight?	☐	☐
44. Are you trying to gain or lose weight?	☐	☐
45. Have anyone recommended you change your weight or eating habits?	☐	☐
46. Do you limit or carefully control what you eat?	☐	☐
47. Do you have any concerns that you would like to discuss with a doctor?	☐	☐

COVID-19 ADDENDUM

48. Have you ever been diagnosed with or suspected you had COVID-19?	☐	☐
If yes, did you have 4 or more days of fever (greater than 100.4°F), and/or 1 or more week of myalgia, chills, or lethargy?	☐	☐
49. Have you ever been hospitalized due to COVID-19 or diagnosed with MIS-C?	☐	☐

FEMALES ONLY

50. Have you ever had a menstrual period?	☐	☐
51. How old were you when you had your first menstrual period?	_____	
52. How many periods have you had in the last year?	_____	

Explain "Yes" answers here:

_____

_____

_____

Allergies: _____

Required for School* and Recommended Immunizations: (please check if student is up-to-date): ☐ Hepatitis A; ☐ Hepatitis B; ☐ Human Papillomavirus (HPV); ☐ Influenza; ☐ Measles, Mumps, Rubella (MMR)*; ☐ Meningococcal; ☐ Polio*; ☐ Tetanus/Diphtheria/Pertussis (Tdap)*; ☐ Varicella (Chickenpox)*

Date of last known tetanus shot (Tdap): _____

PROVIDER'S PHYSICAL EXAMINATION FORM

Name _____ **Date of Birth** _____

Height _____ **Weight** _____ **Pulse** _____ **BP: Left Arm**_____/_____ **Right Arm** _____/_____

Vision R 20/_____ **L 20/**_____ **Corrected: Y N Pupils: Equal** _____ **Unequal** _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Hernia			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hands/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple examiner set-up only.

Notes: _____

_____

_____

CLEARANCE

_____ _____

Typed or printed name of Student Signature of Student

☐ Cleared without restriction

☐ Cleared with recommendations for further evaluation or treatment for: _____

_____

_____

☐ Not cleared for ☐ All sports ☐ Certain sports _____ Reason: _____

Recommendations: _____

_____

_____

Name of physician/medical provider [print or type] _____ Date _____

Address _____ Phone _____

Signature of physician/medical provider _____

PARENT'S OR GUARDIAN'S PERMISSION AND RELEASE

I certify that the information provided by the student/parent(s) is accurate to the best of my knowledge. I hereby give my consent for the above student to engage in approved athletic activities as a representative of his/her school, except those indicated above by the licensed professional. I also give my permission for the team physician, athletic trainer, or other qualified personnel to have access to information provided here as well as to give first aid treatment to this student at an athletic event in case of injury. If emergency service involving medical action or treatment is required and the parents(s) or guardian(s) cannot be contacted, I hereby consent for the student named above to be given medical care by the doctor or hospital selected by the school.

_____ _____

Typed or printed name of parent or guardian Signature of parent or guardian

_____ _____ _____

Date Address Insurance (Company name)

_____ _____ _____ _____

Parent's Home Phone Parent's Work Phone Parent's Cell Phone Additional Phone (if any-specify)

ALL INFORMATION IS TO REMAIN CONFIDENTIAL

(Updated 4/21)

Student-Athlete & Parent/Legal Guardian Concussion Statement

Because of the passage of the Dylan Steiger's Protection of Youth Athletes Act, schools are required to distribute information sheets for the purpose of informing and educating student-athletes and their parents of the nature and risk of concussion and head injury to student athletes, including the risks of continuing to play after concussion or head injury. Montana law requires that each year, before beginning practice for an organized activity, a student-athlete and the student-athlete's parent(s)/legal guardian(s) must be given an information sheet, and both parties must sign and return a form acknowledging receipt of the information to an official designated by the school or school district prior to the student-athletes participation during the designated school year. The law further states that a student-athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from play at the time of injury and may not return to play until the student-athlete has received a written clearance from a licensed health care provider.

Student-Athlete Name:_____

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

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), 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, 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, or licensed health care 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 licensed health care professional to return to play or practice after a concussion.	
	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 have read the concussion symptoms on the Concussion fact sheet.	

_____ _____

Signature of Student-Athlete Date

_____ _____

Signature of Parent/Legal Guardian Date

Chain of Command

Parental/Coaching Responsibilities

Chester-Joplin-Inverness Public Schools institutes a Chain of Command procedure for all communication involving students, parents, and school staff. Most problems that arise in extracurricular activities can easily be resolved through simple and appropriate respect and communication. Professional courtesy and respectful behavior should be observed at all times when addressing an appropriate concern with students, parents, coaches, and administration.

Chain of Command Procedure:

1. **Player to Coach**
   All concerns involving appropriate extracurricular concerns should be first addressed from player to coach.

2. **Player/Parent to Coach**
   If a player has addressed a concern with his/her coach, and does not feel that their concern has been properly addressed, it may then be appropriate for a parent to discuss the matter directly with the coach/coaching staff involved.

3. **Player/Parent to Athletic Director**
   If adequate resolution is not reached between in a parent to coach meeting, the next step is to address the problem with the school Athletic Director. This meeting can be conducted with all parties present or otherwise as the situation dictates.

4. **Player/Parent to Principal**
   If adequate resolution is not reached between a parent and the Activities Director, a parent may seek to address the problem with the school Principal. This meeting can be conducted with all parties present or otherwise as the situation dictates.

5. **Player/Parent to Superintendent**
   If adequate resolution is not reached between a parent and the school Principal, a parent may seek to address the problem with the Superintendent. This meeting can be conducted with all parties present or otherwise as the situation dictates.

6. **Parent to Local School Board**
   If and when a situation or problem cannot be resolved through school staff and administration, parent/players may address their concerns with the School Board in a scheduled meeting with the concern posted in the agenda in an appropriate manner.

I have read and understand the "Chain of Command" policy.

Parental Signature: _____

Player Signature: _____

STUDENT RELATED 3340F CJI Public Schools

Student Drug Testing Consent Form

Participation in school sponsored extracurricular activities at CJI Public Schools is a privilege. Activity Students carry a responsibility to themselves, their fellow students, their families, their school, and their community to set the highest possible examples of conduct, which includes avoiding the use or possession of illegal drugs. Chemical use of any kind is incompatible with participation in extracurricular activities at CJI Public Schools.

CJI Public Schools has adopted the attached Activity Student Drug Testing Policy and the Student Drug Testing Consent for use by all Activity Students at the middle school and high school level. This policy explains in more detail the purpose of drug testing and its implementation. The policy also defines "chemical use" and "illegal drugs".

CONSENT BEFORE PARTICIPATION: Each Activity Student shall be provided with a copy of the Activity Student Drug Testing Policy and this Student Drug Testing Consent, which shall be read, signed and dated by the Activity Student and parent or custodial guardian (if the Activity Student is under age 18) and returned to the school administration before such student shall be eligible to practice or participate in any activities. The consent allows CJI Public Schools to obtain a urine sample from each Activity Student: a) if chosen by the random selection basis; and b) at any time based on a reasonable suspicion to be tested for illegal drugs.

_____

Student's Last Name (please print) First Name MI

I have been given, read, and understood the "Student Activity Drug Testing Policy" and this "Student Drug Testing Consent". I understand that CJI Public Schools enforces the rules applying to the use or possession of illegal drugs as defined in the policy. As a member of an extracurricular activity, I realize that the personal decisions that I make daily in regard to the use or possession of illegal drugs may affect my health and wellbeing, may endanger those around me, and may reflect negatively upon myself, my family, my activity, my school, and my community. If I chose to violate school policy regarding the use or possession of illegal drugs, I understand I will be subject to discipline and restrictions on my participation as outlined in the Policy. I consent to submit to drug testing in accordance with the Student Activity Drug Testing Policy.

_____

Signature of Student Date

We have read and understand the "Activity Student Drug Testing Policy" and this "Student Drug Testing Consent". We desire that the student named above participate in the extracurricular activities of CJI Public Schools. We consent to the implementation and enforcement of the policy, and we agree that the student named above will be subject to the policy. We give our consent to drug testing of this student in accordance with the policy and the procedures implementing the policy. We understand the discipline and restrictions on participation that can be enforced against the student for violations as explained in the policy.

_____

Signature of Parent/Guardian Date

FORM HISTORY:
Adopted:Aug. 15, 2014

CHESTER-JOPLIN-INVERNESS PUBLIC SCHOOLS
MEDICAL/ATHLETIC CONSENT FORM – K-12

STUDENT _____

In the event of an accident, injury, or emergency, I understand that a reasonable attempt will be made to contact me as the parent or guardian of the above named student. However, if the school is not able to contact me, permission is hereby granted to seek the emergency medical treatment necessary for the best interest of the above named student. Medical expenses are the parents/guardians financial responsibility. In case of an emergency or disaster, all students will be at the Lutheran Church Fellowship Hall.

_____ _____
Signature of Parent or Guardian Date

Phone number where parents may be reached:

Office: _____ Name of Family Physician: _____

Home: _____ Phone Number: _____

Cell: _____

Parent Email Address: _____

Mailing & Physical Address: _____

Other: _____

Two local emergency contact numbers if parents cannot be reached:

Name and Relationship: _____

Phone: _____

Name and Relationship: _____

Phone: _____

****

Health History	**Yes**	**No**		**Yes**	**No**
Asthma	___	___			
Kidney injuries	___	___	While competing, do you wear:	___	___
Heart condition or disease	___	___	Glasses	___	___
Diabetes	___	___	Contacts	___	___
*Allergy (medication/foods)	___	___			

Please state: _____

_____

****

The above student has my permission to participate in the following activities for this school year:

____ Basketball ____ Tennis ____ 4-5 Basketball

____ Football ____ Track ____ Wrestling

____ Volleyball ____ Speech & Drama

Montana Authorization to Possess or Self-Administer Asthma, Severe Allergy, or Anaphylaxis Medication

For this student to possess or self-administer asthma, severe allergy, or anaphylaxis medication while in school, while at a school sponsored activity, while under the supervision of school personnel, before or after normal school activities (such as while in before-school or after-school care on school-operated property), or while in transit to or from school or school-sponsored activities, this form must be fully completed by: 1) the prescribing physician/ physician assistant/advanced practice registered nurse, and 2) an authorizing parent, an individual who has executed a caretaker relative educational or medical authorization affidavit, or legal guardian.

Student's Name:_____ School: _____
Sex: (Please circle) Female/Male City/Town: _____
Birth Date: _____/_____/_____ School Year: _____(Must be renewed annually)

Physician's Authorization:
The above named student has my authorization to carry and self administer the following medication:
Medication: (1) _____ Dosage: (1) _____
(2) _____ (2) _____
Reason for prescription(s): _____
Medication(s) to be used under the following conditions (times or special circumstances): _____
_____

I confirm that this student has been instructed in the proper use of this medication and is able to self-administer this medication without school personnel supervision. I have formulated and provided to the parent/guardian or caretaker relative a written treatment plan for managing asthma, severe allergies, or anaphylaxis episodes and for medication use by this student during school hours and school activities.

_____ _____ _____
Signature of Physician/PA/APRN Phone Number Date

Authorization by Parent, an individual who has executed a caretaker relative educational or medical authorization affidavit, or Guardian

As the parent, individual who has executed a caretaker relative educational or medical authorization affidavit, or guardian of the above named student, I confirm that this student has been instructed by his/her health care provider on the proper use of this/these medication(s). He/she has demonstrated to me that he/she understands the proper use of this medication. He/she is physically, mentally, and behaviorally capable to assume this responsibility. He/she has my permission to self-medicate as listed above, if needed. If he/she has used epinephrine during school hours, he/she understands the need to alert the school nurse or other adult at the school who will provide follow-up care, including making a 9-1-1 emergency call.

I acknowledge that the school district or nonpublic school and its employees and agents are not liable as a result of any injury arising from the self-administration of medication by the student, and I indemnify and hold them harmless for such injury, unless the claim is based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional tort.

I agree to work with the school in establishing a plan for use and storage of backup medication. This will include a predetermined location to keep backup medication to which my child has access in the event of an asthma, severe allergy, or anaphylaxis emergency. I have provided the following backup medication: _____
_____.

I understand that in the event the medication dosage is altered, a new "self-administration form" must be completed, or the health care provider may rewrite the order on his/her prescription pad, and I, the parent/caretaker relative/guardian, will sign the new form and assure the new order is attached.

I understand it is my responsibility to pick up any unused medication at the end of the school year, and the medication that is not picked up will be disposed of.

I authorize the school administration to release this information to appropriate school personnel and classroom teachers.

Parent/Guardian, Caretaker Relative Signature: _____ Date: _____

(Original signed authorization to the school; a copy of the signed authorization to the parent/guardian and health care provider) See, generally, Mont. Code Ann. § 20-5-420.

A Fact Sheet for **ATHLETES**

WHAT IS A CONCUSSION?

A concussion is a brain injury that:

- Is caused by a bump or blow to the head
- Can change the way your brain normally works
- Can occur during practices or games in any sport
- Can happen even if you haven't been knocked out
- Can be serious even if you've just been "dinged"

WHAT ARE THE SYMPTOMS OF A CONCUSSION?

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light
- Bothered by noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion
- Does not "feel right"

WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

- **Tell your coaches and your parents.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach if one of your teammates might have a concussion.
- **Get a medical checkup.** A doctor or health care professional can tell you if you have a concussion and when you are OK to return to play.
- **Give yourself time to get better.** If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a second concussion. Second or later concussions can cause damage to your brain. It is important to rest until you get approval from a doctor or health care professional to return to play.

HOW CAN I PREVENT A CONCUSSION?

Every sport is different, but there are steps you can take to protect yourself.

- Follow your coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Use the proper sports equipment, including personal protective equipment (such as helmets, padding, shin guards, and eye and mouth guards). In order for equipment to protect you, it must be:

> The right equipment for the game, position, or activity
> Worn correctly and fit well
> Used every time you play

Remember, when in doubt, sit them out!
It's better to miss one game than the whole season.

A Fact Sheet for **PARENTS**

WHAT IS A CONCUSSION?

A concussion is a brain injury. Concussions are caused by a bump or blow to the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

You can't see a 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 your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

WHAT ARE THE SIGNS AND SYMPTOMS OF A CONCUSSION?

Signs Observed by Parents or Guardians

If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs and symptoms of a concussion:

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

Symptoms Reported by Athlete

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

HOW CAN YOU HELP YOUR CHILD PREVENT A CONCUSSION?

Every sport is different, but there are steps your children can take to protect themselves from concussion.

- Ensure that they follow their coach's rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.
- Make sure they wear the right protective equipment for their activity (such as helmets, padding, shin guards, and eye and mouth guards). Protective equipment should fit properly, be well maintained, and be worn consistently and correctly.
- Learn the signs and symptoms of a concussion.

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

1. Seek medical attention right away. A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to sports.

2. Keep your child out of play. Concussions take time to heal. Don't let your child return to play until a health care professional says it's OK. Children who return to play too soon—while the brain is still healing—risk a greater chance of having a second concussion. Second or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.

3. Tell your child's coach about any recent concussion. Coaches should know if your child had a recent concussion in ANY sport. Your child's coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

Remember, when in doubt, sit them out!
It's better to miss one game than the whole season.

Be Prepared

A concussion is a type of traumatic brain injury, or TBI, caused by a bump, blow, or jolt to the head that can change the way your brain normally works. Concussions can also occur from a blow to the body that causes the head to move rapidly back and forth. Even a "ding," "getting your bell rung," or what seems to be mild bump or blow to the head can be serious. Concussions can occur in any sport or recreation activity. So, all coaches, parents, and athletes need to learn concussion signs and symptoms and what to do if a concussion occurs.

SIGNS AND SYMPTOMS OF A CONCUSSION

SIGNS OBSERVED BY PARENTS OR GUARDIANS	SYMPTOMS REPORTED BY YOUR CHILD OR TEEN	
•Appears dazed or stunned •Is confused about events •Answers questions slowly •Repeats questions •Can't recall events prior to the hit, bump, or fall •Can't recall events after the hit, bump, or fall •Loses consciousness (even briefly) •Shows behavior or personality changes •Forgets class schedule or assignments	**Thinking/Remembering:** •Difficulty thinking clearly •Difficulty concentrating or remembering •Feeling more slowed down •Feeling sluggish, hazy, foggy, or groggy **Physical:** •Headache or "pressure" in head •Nausea or vomiting •Balance problems or dizziness •Fatigue or feeling tired •Blurry or double vision •Sensitivity to light or noise •Numbness or tingling •Does not "feel right"	**Emotional:** •Irritable •Sad •More emotional than usual •Nervous **Sleep*:** •Drowsy •Sleeps less than usual •Sleeps more than usual •Has trouble falling asleep **Only ask about sleep symptoms if the injury occurred on a prior day.*

LINKS TO OTHER RESOURCES

- CDC –Concussion in Sports
  - http://www.cdc.gov/concussion/sports/index.html
- National Federation of State High School Association/ Concussion in Sports
  - www.nfhslearn.com
- Montana High School Association – Sports Medicine Page
  - http://www.mhsa.org/SportsMedicine/SportsMed.htm