315 N Washington Street
Viborg, SD 57070-0368
Ph: (605) 326-5161
Fx: (605) 326-5734
pioneermemorial.org

PIONEER MEMORIAL
HOSPITAL & HEALTH SERVICES

Attention: Viborg-Hurley Student Athletes and Parents,

Pioneer Memorial Hospital & Health Services would like to offer medical services for athletic physical examinations. Two options are available:

Option 1 – To be done at the SCHOOL

- When: **Wednesday, May 15 starting at 8:30am**
- Where: **Viborg AND Hurley Schools, same date and time**
- Please bring the athletic physical forms with your part completed. **Physicals will not be done without all appropriate parent/guardian signatures**. Forms are available through your school.
- **$30** is due when you arrive on this date.

Option 2 – To be done at the CLINIC

- Please make an appointment with the clinic:

Centerville Medical Clinic	**563-2411**
Parker Medical Clinic	**297-3888**
Viborg Medical Clinic	**326-5201**

- **What to schedule? Sports physical or well-child visit?**
  - An annual well-child visit includes a comprehensive look at the overall health & well-being, with both physical and mental health concerns addressed. Sports physicals focus particularly on physical growth, cardiovascular health, musculoskeletal health, and risk reduction.
  - ***A well-child visit can double as a sports physical, but a sports physical can't be considered a well-child visit.***
- Please bring the athletic physical forms with your part completed. **Physicals will not be done without all appropriate parent/guardian signatures**. Forms are available through your school.
- Payment is due at the time of service. Pricing if done in the clinic:
  - **Sports Physical**: **$30.00** for sports physicals done in the clinic. No insurance claims will be filed at this price. Any additional testing (i.e. laboratory, radiology, and immunizations) is not included in the sports physical price.
  - **Well-child visit:** The well-child visit will be filed with your insurance company at the standard price. Most insurance companies fully cover well-child visits once a year; this can be confirmed by calling the phone number on your insurance card.

Please feel free to contact the Viborg Medical Clinic at 605-326-5201 with questions.

Sincerely,

Tonya Rudd, MS, RN

Tonya Rudd, MS, RN
Director of Clinic Operations

Sports physical **OR** well-child visit?

Well-child visits cover All the bases!

An annual well-child visit includes a comprehensive look at the **overall health & well-being**, with both physical and mental health concerns addressed. **This is especially important for teens.**

The well-child visit only takes about 20 minutes, why not cover both bases with one appointment?

	SPORTS PHYSICAL	OR	WELL-CHILD VISIT
PHYSICAL GROWTH	✓		✓
PHYSICAL DEVELOPMENT			✓
SOCIAL COMPETENCE			✓
ACADEMIC COMPETENCE			✓
EMOTIONAL WELL-BEING			✓
RISK REDUCTION	✓		✓
VIOLENCE & INJURY PREVENTION			✓
CARDIOVASCULAR HEALTH	✓		✓
MUSCULOSKELETAL HEALTH	✓		✓
REPRODUCTION			✓
SEXUAL HEALTH			✓

Remember, a well-child visit **can double** as a sports physical, but a sports physical **can't** be considered a well-child visit.

** Most insurance companies cover well-child visits. Check with your Insurance company

CALL TO SCHEDULE AN APPOINTMENT!

Centerville Medical Clinic (605) 563-2411
Parker Medical Clinic (605) 297-3888
Viborg Medical Clinic (605) 326-5201

PIONEER MEMORIAL
HOSPITAL & HEALTH SERVICES

Dr. Denise Hanisch, MD

Patient name _____ _____
Legal name Last First Middle initial Soc. Sec. #

Alternative names/maiden/nicknames _____ Hispanic/Latino Ethnical Background ☐ Yes ☐ No

Sex ☐ Male ☐ Female Birth date _____ Race _____

Marital status ☐ M ☐ S ☐ Divorce ☐ Widowed ☐ Separated Email _____

Address _____
Street PO Box City State Zip

Home phone ( )	Work phone ( )	Cell phone ( )
Employer	Occupation	

Employer address _____
Street PO Box City State Zip

Spouse's name	Birth date	Soc. Sec. #
Employer	Occupation	
Work phone ( )	Cell phone ( )	

Employer address _____
Street PO Box City State Zip

RESPONSIBLE PARTY / BILLING INFORMATION (If patient is a minor)

Mother's name	Birth date	Soc. Sec. #
Address _____ Street PO Box City State Zip		Home phone ( )
		Work phone ( )
Employer	Occupation	Cell phone ( )

Employer address _____
Street PO Box City State Zip

Father's name	Birth date	Soc. Sec. #
Address _____ Street PO Box City State Zip		Home phone ( )
		Work phone ( )
Employer	Occupation	Cell phone ( )

Employer address _____
Street PO Box City State Zip

EMERGENCY CONTACT

Name	Relationship to patient
Address _____ Street PO Box City State Zip	
Home phone ( )	Work phone ( ) Cell phone ( )

Pioneer Memorial
Viborg Medical Clinic
SANFORD

PATIENT INFORMATION

VMC 2005
Revised 05/30/14

NAME _____

DOB _____

FINANCIAL RESPONSIBILITY

I agree that I am financially responsible for all charges related to services provided by Pioneer Memorial Hospital & Health Services (PMHHS). I also agree to abide by PMHHS' payment guidelines, including payment of any periodic late fees. If I have questions about my financial responsibility for PMHHS' charges, or would like to see a copy of the Collection Policy; I may contact PMHHS' Patient Financial Services

Further, if I am provided health care services by a health care provider other than PMHHS, while a patient within a PMMHS facility or entity, I am financially responsible for all charges related to services provided by those health care providers. PMHHS' billing statements will not include charges by health care providers who are independent of PMHHS.

Additionally, I agree PMHHS, or its third party vendor, may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

ASSIGNMENT OF PAYER BENEFITS

I agree PMHHS and my attending health care provider will bill and provide necessary health information to any Payers. "Payers" are any health care insurance, private or government health plan or insurance policy that I have or another third party that will pay the charges I have incurred. All Payers may make payments directly to PMHHS and my attending health care provider. My signature on this form is my authorized signature for the filing of a claim and request for direct payment of benefits by any Payer to PMHHS and my attending health care provider. I agree that unless PMHHS or my attending health care provider have agreed with the Payer to accept payment from the Payer as full payment, I am responsible to pay any charges not paid by the Payer. These charges can include but are not limited to co-pays, deductibles, co-insurance amounts and charges for non-covered services.

MEDICARE BENEFICIARY REQUEST FOR PAYMENT AND ASSIGNMENT OF BENEFITS

If I am a Medicare beneficiary, I request that payment of authorized Medicare benefits be made on my behalf to PMHHS and my attending health care provider for any services furnished me by PMHHS and my attending health care provider, including physician services. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits for related services.

ACKNOWLEDGMENT

I have read the information above, and I have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient identified in the below label on this form, I represent that I am authorized by law to agree to these conditions on the patient's behalf and am the authorized representative of the patient. A copy of this form is as effective and valid as the original.

_____	_____	_____ a.m./p.m.
Signature of Patient or Authorized Person	Date	Time

_____

Relationship to Patient (if not patient signing)

Your health data is stored in an electronic medical record known as One Chart. One Chart is used by this health care provider and others we have a direct relationship with. This form explains how your health record in One Chart is shared with friends, family and other unrelated health care providers. This is called disclosure and happens for:

Friends and Family
Privacy laws allow verbal (spoken) health data to be shared with family and close personal friends. This sharing is allowed when family and friends are directly involved in a patient's care or payment for care. Please ask staff at the reception desk to limit that sharing if you have concerns about family and friends getting your health data. Family and friends may not receive copies of your records without your consent.

Payers for Payment
Privacy laws allow health data related to services received to be shared for payment. This means your health record may be shared with your health insurance company or other sources that help pay your bill.

- I agree to tell my health care provider when I arrive if I do not want records from that visit to be shared for payment. I understand that payment must be made by me alone.

From Payers and Networks
Your health insurance company may want to share your health data with us to improve the quality of your care. This may include your records from past, current and future treatment at other health care providers.

- I agree that my health insurance company network including accountable care organizations may share my health and account records from any other sources with my current care provider.

Health Care Providers for Treatment
Health data can be shared between health care providers to help with your care, especially in an emergency.

- I consent to share my health record with other health care organizations directly involved in my current or future treatment. This sharing may occur on paper or by electronic means. This sharing includes regional or national health information exchanges (health care provider groups). This consent does not include sharing of records by or from a drug or alcohol abuse treatment program unless I have given that program written consent.

This consent will be forever unless you stop it by writing our medical records department. Stopping this consent will not change releases that have already been made.

Patient or Legal Representative Signature	Date	Time

Relationship to Patient (if signing for patient)

315 N. Washington•Viborg, SD 57070
605-326-5161 Fax: 605-326-5734
www.pioneermemorial.org

SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION
ANNUAL PARENT OR GUARDIAN PERMIT

I hereby give my consent for _____ GRADE _____
Name (Please Print) 2019-20 School Year

who was born at _____
City, Town, County, State

on _____ to compete in SDHSAA approved athletics for _____ High School
Date of Birth

during the 2019-20 school year.

I/We give our permission for our son/daughter to participate in organized high school athletics, realizing that such activity involves the potential for injury which is inherent in all sports.

Date _____, 20_____ Signed _____
Parent or Legal Guardian

THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL.

INITIAL PRE-PARTICIPATION HISTORY

SEE REVERSE SIDE FOR

HEALTH HISTORY QUESTIONNAIRE

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: ☐ 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

SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION PHYSICAL EXAMINATION FORM

Date Exam Expires: _____

Check Appropriate Physical Exam Term:

___Annual ___Biennial___Triennial

NAME _____ GRADE _____ DATE OF BIRTH _____

CHECK ONE: _____ MALE _____ FEMALE (2019-20 School Year)

1. Blood pressure (sitting) _____/_____ Repeat in 5 minutes, if elevated _____/_____.
2. Height _____
3. Weight _____

	Normal	Abnormal	COMMENTS
4. Vision 20/_____(L) 20/_____(R)			
5. Head			
6. Mouth (dentures, braces?)			
7. Eyes (contacts?)			
8. Chest/lung			
9. Heart			
a. Heart sounds			
b. Murmurs			
c. pulse (rad. vs fem.)			
d. rhythm			
10. Abdomen			
a. liver or spleen			
b. masses			
11. Genitalia (males only)			
a. hernias			
b. testes			
12. Orthopedic			
a. cervical spine			
b. shoulder shrug			
c. deltoid			
d. arms/elbow			
e. hands			
f. hips			
g. knees			
h. ankles			
i. Scoliosis			

SPORTS PARTICIPATION RECOMMENDED FOR:

_____ Cleared for ALL (*collision, contact/endurance sports*, and *other sports*)

_____ Cleared only for *contact/endurance sports* and *other sports*

_____ Cleared only for *other sports*

Definition: [Collision=Football and Wrestling]; [Contact/Endurance Sports=Basketball, Cross Country, Gymnastics, Soccer, Tennis, Track, Volleyball, Competitive Cheer and Competitive Dance]; [Other Sports=Golf]

_____ Cleared for ALL, but with recommendations for further evaluation or treatment for _____

_____ Above clearance to be granted only after _____

_____ **Clearance cannot be given at this time because** _____

NAME OF EXAMINER (PRINT) _____ DATE _____, 20_____

SIGNATURE OF EXAMINER _____

NOTE: The following licensed medical personnel are qualified to perform the examination and certify the health of the student athlete: Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, licensed Physician Assistant and licensed Nurse Practitioner.

This is the form that the South Dakota High School Activities Association recommends to those member schools that feel it is important to get consent from parents and/or legal guardians for medical treatment when away from home on road trips for various activities. This form should be kept on file at the school and another copy should travel with each team on which the athlete competes.

CONSENT FOR MEDICAL TREATMENT

I am the **PLEASE CIRCLE ONE** Mother Father Legal Guardian of_____

_____, who participates in co-curricular activities for _____

_____ High School. I hereby consent to any medical services that may be required while said child is under the supervision of an employee of the _____ School District while on a school-sponsored activity and hereby appoint said employee to act on behalf in securing necessary medical services from any duly licensed medical provider.

Dated this_____ day of _____, 20_____

Parent(s)/Legal Guardian Signature:_____

CONSENT OF CHILD

I, _____, have read the above Consent For Medical Treatment Form signed by my **(PLEASE CIRCLE ONE)** Mother Father Legal Guardian and join with **(PLEASE CIRCLE ONE)** him her in the consent.

Dated this _____ day of _____, 20_____

Student's Signature:_____

SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION
ANNUAL PARENT AND STUDENT CONSENT FORM

School Year: 2019-2020 Name of High School: _____

Name of Student: _____

Date of Birth: _____ Place of Birth: _____

The Parent and Student hereby:

1. Understand and agree that participation in SDHSAA sponsored activities is voluntary on the part of the student and is considered a privilege.
2. Understand and agree that (a) by this Consent Form the SDHSAA has provided notification to the parent and student of the existence of potential dangers associated with athletic participation; (b) participation in any athletic activity may involve injury of some type; (c) the severity of such injuries can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries such as injuries to the body's bones, joints, ligaments, tendons, or muscles. Catastrophic injuries to the head, neck and spinal cord and concussions may also occur. On rare occasions, injuries so severe as to result in total disability, paralysis and death; and (d) even with the best coaching, use of the best protective equipment, and strict observance of rules, injuries are still a possibility.
3. Consent and agree to participation of the student in SDHSAA activities subject to all SDHSAA bylaws and rules interpretations for participation in SDHSAA sponsored activities, and the activities rules of the SDHSAA member school for which the student is participating; and
4. Consent and agree that personally identifiable directory information may be disclosed about the student as a result of his/her participation in SDHSAA sponsored activities. Such directory information may include, but is not limited to, the student's photograph, name, grade level, height, weight, and participation in officially recognized activities and sports. ***If I do not wish to have any or all such information disclosed, I must notify the above mentioned high school, in writing, of our refusal to allow disclosure of any or all such information prior to the student's participation in sponsored activities.***

I acknowledge that I have read paragraphs one (1) through four (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participating in activities.

DATED this _____day of _____, 20_____

_____ _____

Name of Student (Print Name) Student Signature

I am the student's parent/guardian. I acknowledge that I have read paragraphs (1) through (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities. I hereby give my permission for _____ (student's name) to practice and compete for the above named high school in activities approved by the SDHSAA.

DATED this _____ day of _____, 20_____

_____ _____

Parent/Guardian (Print Name) Parent/Guardian Signature

THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL

CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM (HIPAA)

Student Name _____ Date of Birth _____

1. I authorize the use or disclosure of the above named individual's health information including the Initial and Interim Pre-Participation History and Physical Exam information pertaining to a student's ability to participate in South Dakota High School Activities Association sponsored activities. Such disclosure may be made by any Health Care Provider generating or maintaining such information.

2. The information identified above may be used by or disclosed to the school nurse, athletic trainer, coaches, medical providers and other school personnel involved in the care of this student.

3. This information for which I am authorizing disclosure will be used for the purpose of determining the student's eligibility to participate in extracurricular activities, any limitations on such participation and any treatment needs of the student.

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the school administration. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

5. This authorization will expire on July 1, 2020.

6. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

7. I understand authorizing the use or disclosure of the information identified above is voluntary. However, a student's eligibility to participate in extracurricular activities depends on such authorization. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of Parent Date

_____ _____
Signature of Student (If Over 18) Date

This form must be completed annually and must be available for inspection at the school

RETURN TO COMPETITION, PRACTICE, OR TRAINING

This form is to be used after a youth athlete is removed from, and not returned to, competition, practice, or training after exhibiting concussion symptoms. The youth athlete should not be returned to competition, practice, or training until written authorization is obtained from an appropriate health care professional and the parent/guardians. A licensed health care provider is a person who is:
(1) Registered, certified, licensed, or otherwise recognized in law by the State of South Dakota to provide medical treatment; and
(2) Trained and experienced in the evaluation, management, and care of concussions.

This form should be kept on file at the school and need not be forwarded to the SDHSAA Office.

Athlete:_____ School: _____ Grade: _____

Sport: _____ Date of Injury: _____

REASON FOR ATHLETE'S INCAPACITY

_____
_____
_____

Guidelines for returning to competition, practice, or training after a concussion

Note: Each step should be completed with no concussion symptoms before proceeding to the next step.

1. No activity, complete rest with no symptoms.
2. Light exercises: walking or stationary cycling with no symptoms.
3. Sport specific activity without body contact and no symptoms.
4. Practice without body contact and no symptoms. Resume resistance training.
5. Practice with body contact and no symptoms.
6. Return to game play with no symptoms.

Note:

1. If symptoms return at any time during the rehabilitation process, wait until asymptomatic for 1 full day, then re-start at the previous step.
2. Never return to competition with symptoms.
3. Do not use "smelling salts".
4. **When in doubt, sit them out.**

HEALTH CARE PROFESSIONAL'S ACTION

I have examined the named student-athlete following this episode and determined the following:

_____ **Permission is granted** for the athlete to return to competition, practice, or training

_____ **Permission is not granted** for the athlete to return to competition, practice, or training

COMMENT:_____
_____
_____

_____ Date: _____
Health Care Professional

_____ Date: _____
Parent/Guardian

_____ Date: _____
School Administrator

CONCUSSION FACT SHEET FOR ATHLETES

What is a concussion?

A concussion is a brain injury that:

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

All concussions are serious. A concussion can affect your ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most people with a concussion get better, but it is important to give your brain time to heal.

What are the symptoms of a concussion?

You can't see a concussion, but you might notice one or more of the symptoms listed below or that you "don't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

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 right away if you think you have a concussion or if one of your teammates might have a concussion.
- **Get a medical check-up.** A doctor or other health care professional can tell if you have a concussion and when it is OK to return to play.
- **Give yourself time to get better.** If you have a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have another concussion. Repeat concussions can increase the time it takes for you to recover and may cause more damage to your brain. It is important to rest and not return to play until you get the OK from your health care professional that you are symptom-free.

How can I prevent a concussion?

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

- Use the proper sports equipment, including personal protective equipment. In order for equipment to protect you, it must be:
  - The right equipment for the game, position, or activity
  - Worn correctly and the correct size and fit
  - Used every time you play or practice
- Follow you coach's rules for safety and the rules of the sport
- Practice good sportsmanship at all times

It's better to miss one game than the whole season.

Student's Name (please print)_____ Date: _____

Student's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

THIS FORM MUST BE SIGNED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL

CONCUSSION FACT SHEET FOR PARENTS

What is a concussion?

A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even or what seems to be a mild bump or blow to the head can be serious.

What are the signs and symptoms?

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 after the injury. If your teen reports, one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

Signs Observed By Parents or Guardians	Symptoms Reported by Athlete
• 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 mood, behavior, or personality changes • Can't recall events prior to hit or fall • Can't recall events after hit or fall	• Headache or "pressure" in head • Nausea or vomiting • Balance problems or dizziness • Double or blurry vision • Sensitivity to light or noise • Feeling sluggish, hazy, foggy, or groggy • Concentration or memory problems • Confusion • Just not "feeling right" or is "feeling down"

How can you help your teen prevent a concussion?

Every sport is different, but there are steps your teens can take to protect themselves from concussion and other injuries.

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport
- Encourage them to practice good sportsmanship at all times.

What should you do if you think your teen has a concussion?

1. **Keep your teen out of play.** If your teen has a concussion, her/his brain needs time to heal. Don't let your teen return to play the day of the injury and until a health care professional, experienced in evaluating for concussion, says your teen is symptom-free and it's OK to return to play. A repeat concussion that occurs before the brain recovers from the first – usually within a short period of time (hours, days, or weeks) – can slow recovery or increase the likelihood of having long-term problems. In rare cases, repeat concussions can result in edema (brain swelling), permanent brain damage, and even death.
2. **Seek medical attention right away.** A health care professional experienced in evaluating for concussion will be able to decide how serious the concussion is and when it is safe for your teen to return to sports.
3. **Teach your teen that it's not smart to play with a concussion.** Rest is key after a concussion. Sometimes athletes wrongly believe that it shows strength and courage to play injured. Discourage others from pressuring injured athletes to play. Don't let your teen convince you that s/he's "just fine".
4. **Tell all of your teen's coaches and the student's school nurse about ANY concussion.** Coaches, school nurses, and other school staff should know if your teen has ever had a concussion. Your teen may need to limit activities while s/he is recovering from a concussion. Things such as studying, driving, working on a computer, playing video games, or exercising may cause concussion symptoms to reappear or get worse. Talk to your health care professional, as well as your teen's coaches, school nurse, and teachers. If needed, they can help adjust your teen's school activities during her/his recovery.

Parent/Guardian's Name (Please print) _____ Date _____, 20_____

Parent/Guardian's Signature _____ Date _____, 20_____

THIS FORM MUST BE SIGNED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL