

Delaware Interscholastic Athletic Association Pre-Participation Physical Evaluation

The DIAA pre-participation physical evaluation and consents form consist of seven pages. Pages one, two and four require your signature while pages five, six and seven are references for you to keep. Page three requires the exam date and physician's signature. Pages three and four require the clearance to participate date and physician's signature. **The student must be cleared to participate on or after April 1 based on a physical examination conducted within 12 months of the signature. The clearance is valid through June 30 of the following school year.**

Name of Athlete: _____ School: _____

Grade: _____ Age: _____ Gender: _____ Date of Birth: _____ Phone: _____

Parent/Guardian Name: (Please Print): _____

PARENT/GUARDIAN/STUDENT CONSENTS

_____ has my permission to participate in all interscholastic sports **NOT** checked below?
(Name of Athlete)

NOTE- If you check any sport below the athlete will NOT be permitted to participate in that sport.

| | | | | |
|---------------------------------------|-------------------------------------|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Basketball | <input type="checkbox"/> Cheerleading | <input type="checkbox"/> Cross Country | <input type="checkbox"/> Crew |
| <input type="checkbox"/> Field Hockey | <input type="checkbox"/> Football | <input type="checkbox"/> Golf | <input type="checkbox"/> Ice Hockey | <input type="checkbox"/> Lacrosse (B) |
| <input type="checkbox"/> Lacrosse (G) | <input type="checkbox"/> Soccer | <input type="checkbox"/> Softball | <input type="checkbox"/> Squash | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Tennis | <input type="checkbox"/> Track | <input type="checkbox"/> Volleyball | <input type="checkbox"/> Wrestling | |

- My permission extends to all interscholastic activities whether conducted on or off school premises. I have read and discussed the **Parent/Player Concussion Information Form; Symptoms and Risk Factor for Sudden Cardiac Arrest form;** and the list of items that protect against the loss of athletic eligibility, with said participant and I will retain those pages for my reference. I have also discussed with him/her and we understand that physical injury, including paralysis, coma or death can occur as a result of participation in interscholastic athletics. I waive any claim for injury or damage incurred by said participant while participating in the activities NOT checked above.

Parent Signature: _____ **Date:** _____

Student Signature: _____ **Date:** _____

- To enable DIAA and its full and associate member schools to determine whether herein named student is eligible to participate in interscholastic athletics, I hereby consent to the release of any and all portions of school record files, beginning with the sixth grade, of the herein named student, including but not limited to, birth and age records, name and residence of student's parent(s), guardian(s) or Relative Care Giver, residence of student, health records, academic work completed, grades received and attendance records.

Parent Signature: _____ **Date:** _____

- I further consent to DIAA's and its full and associate member schools use of the herein named student's name, likeness, and athletically related information in reports of interscholastic practices, scrimmages or contests, promotional literature of the association, and other materials and releases related to interscholastic athletics.

Parent Signature: _____ **Date:** _____

- By this signature, I hereby consent to allow the physician(s) and other health care provider(s) selected by myself or the schools to perform a pre-participation examination on my child and to provide treatment for any injury received while participating in or training for athletics for his/her school. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation, with coaches, medical staff, Delaware Interscholastic Athletic Association, and other school personnel as deemed necessary. Such information may be used for injury surveillance purposes.

Parent Signature: _____ **Date:** _____

- By this signature, I agree to notify the physician and school of any health changes during the school year that could impact participation in interscholastic athletics.

Parent Signature: _____ **Date:** _____

Preparticipation Physical Evaluation HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician.)

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 | MEDICAL QUESTIONS | Yes | No |
|--|-----|----|---|-----|----|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason? | | | 26. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____ | | | 27. Have you ever used an inhaler or taken asthma medicine? | | |
| 3. Have you ever spent the night in the hospital? | | | 28. Is there anyone in your family who has asthma? | | |
| 4. Have you ever had surgery? | | | 29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| HEART HEALTH QUESTIONS ABOUT YOU | Yes | No | 30. Do you have groin pain or a painful bulge or hernia in the groin area? | | |
| 5. Have you ever passed out or nearly passed out DURING or AFTER exercise? | | | 31. Have you had infectious mononucleosis (mono) within the last month? | | |
| 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | | 32. Do you have any rashes, pressure sores, or other skin problems? | | |
| 7. Does your heart ever race or skip beats (irregular beats) during exercise? | | | 33. Have you had a herpes or MRSA skin infection? | | |
| 8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____ | | | 34. Have you ever had a head injury or concussion? | | |
| 9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) | | | 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise? | | | 36. Do you have a history of seizure disorder? | | |
| 11. Have you ever had an unexplained seizure? | | | 37. Do you have headaches with exercise? | | |
| 12. Do you get more tired or short of breath more quickly than your friends during exercise? | | | 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | | |
| HEART HEALTH QUESTIONS ABOUT YOUR FAMILY | Yes | No | 39. Have you ever been unable to move your arms or legs after being hit or falling? | | |
| 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)? | | | 40. Have you ever become ill while exercising in the heat? | | |
| 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? | | | 41. Do you get frequent muscle cramps when exercising? | | |
| 15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? | | | 42. Do you or someone in your family have sickle cell trait or disease? | | |
| 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? | | | 43. Have you had any problems with your eyes or vision? | | |
| BONE AND JOINT QUESTIONS | Yes | No | 44. Have you had any eye injuries? | | |
| 17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? | | | 45. Do you wear glasses or contact lenses? | | |
| 18. Have you ever had any broken or fractured bones or dislocated joints? | | | 46. Do you wear protective eyewear, such as goggles or a face shield? | | |
| 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? | | | 47. Do you worry about your weight? | | |
| 20. Have you ever had a stress fracture? | | | 48. Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 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) | | | 49. Are you on a special diet or do you avoid certain types of foods? | | |
| 22. Do you regularly use a brace, orthotics, or other assistive device? | | | 50. Have you ever had an eating disorder? | | |
| 23. Do you have a bone, muscle, or joint injury that bothers you? | | | 51. Do you have any concerns that you would like to discuss with a doctor? | | |
| 24. Do any of your joints become painful, swollen, feel warm, or look red? | | | FEMALES ONLY | | |
| 25. Do you have any history of juvenile arthritis or connective tissue disease? | | | 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 _____

Preparticipation Physical Evaluation PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

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

| EXAMINATION | | |
|---|--------------|--|
| Height _____ | Weight _____ | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| BP _____ / _____ (_____ / _____) | Pulse _____ | Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N |
| 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 | | |

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
^bConsider GU exam if in private setting. Having third party present is recommended.
^cConsider 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).

Health Care Provider: Print/type Name _____ Signature _____, MD, DO, PA, or NP

Address _____ Phone _____

Date of Exam: _____ Date Cleared to Participate: _____

SCHOOL ATHLETE MEDICAL CARD

(Parent/Guardian: Please complete Sections 1, 2 & 3. Please print.)

Section 1: Contact /Personal Information

Name: _____ Sport(s): _____
Age: _____ Grade: _____ Birthdate: _____
Guardian Name: _____
Address: _____
Phone: (H) _____ (W): _____ (C): _____ (P) _____
Other Authorized Person To Contact In Case Of Emergency: _____
Name: _____ Phone(s): _____
Name: _____ Phone(s): _____
Preference Of Physician (And Permission To Contact If Needed): _____
Name: _____ Phone: _____
Hospital Preference: _____ Insurance: _____
Policy #: _____ Group: _____ Phone: _____

Section 2: Medical Information

Medical Illnesses: _____
Last Tetanus (Mo/Yr): _____ Allergies: _____
Medications: _____
(Any medications that may be taken during competition require a physician's note.)
Previous Head/Neck/Back Injury: _____
Heat Disorder, Or Sickle Cell Trait: _____
Previous Significant Injuries: _____
Any Other Important Medical Information: _____

Section 3: Consent for Athletic Conditioning, Training and Health Care Procedures

I hereby give consent for my child to participate in the school's athletic conditioning and training program, and to receive any necessary healthcare treatment including first aid, diagnostic procedures, and medical treatment, that may be provided by the treating physicians, nurses, athletic trainers, or other healthcare providers employed directly or through a contract by the school, or the opposing team's school. The healthcare providers have my permission to release my child's medical information to other healthcare practitioners and school officials. In the event I cannot be reached in an emergency I give permission for my child to be transported to receive necessary treatment. I understand that Delaware Interscholastic Athletic Association or its associates may request information regarding the athlete's health status, and I hereby give my permission for the release of this information as long as the information does not personally identify my child.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____
ATHLETE SIGNATURE: _____ Date: _____

Section 4: Clearance for Participation

_____ Cleared without restrictions _____ Cleared with the following restrictions: _____
Health Care Provider's Signature: _____ MD/DO, PA, NP Date: _____

For office use only: This card is valid from April 1, 20 _____ through June 30, 20 _____

Note: If any changes occur, a new card should be completed by the parent/guardian. The original card should be kept on file in the school athletic director's or athletic trainer's office. A copy should be kept in the sports' athletic kits. This card contains personal medical information and should be treated as confidential by the school, its employees, agents, and contractors.

Name of School: _____ Name of ATC: _____



Delaware Interscholastic Athletic Association Parent/ Player Concussion Information Form

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a “ding” or a bump on the head can be serious. You can’t see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:

| | | |
|------------------|-------------------------|------------------------|
| Headaches | Pressure in head | Nausea or vomiting |
| Neck pain | Balance problems | Dizziness |
| Disturbed vision | Light/noise sensitivity | Sluggish |
| Feeling foggy | Drowsiness | Changes in sleep |
| Amnesia | “Don’t feel right” | Low energy |
| Sadness | Nervousness | Irritability |
| Confusion | Repeating questions | Concentration problems |

Signs observed by teammates, parents and coaches may include:

| | |
|---|--------------------------|
| Appears dazed | Vacant facial expression |
| Confused about assignment | Forgets plays |
| Unsure of game/score etc | Clumsy |
| Responds slowly | Personality changes |
| Seizures | Behavior changes |
| Loss of consciousness | Uncoordinated |
| Can’t recall events before or after hit | |

What can happen if my child keeps on playing with a concussion or returns to soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one (second impact syndrome). This can lead to prolonged recovery, or even to severe brain swelling with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often under report symptoms of injuries, and concussions are no different. As a result, education of administrators, coaches, parents and students is the key for the student-athlete’s safety.

If you think your child has suffered a concussion:

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. You should also inform your child’s coach if you think that your child may have a concussion Remember it is better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information from the CDC on concussions you can go to:

<https://www.cdc.gov/headsup/youthsports/index.html>

For a current update of DIAA policies and procedures on concussions you can go to:

<http://www.doe.k12.de.us/Page/3298>

For a free online video on concussions you can go to:

<https://nfhslearn.com/courses/61064/concussion-in-sports>

All parents and players must sign the signature portion of the DIAA PPE indicating they have read and understand the above.



SUDDEN CARDIAC ARREST AWARENESS FORM

Revised 2018

What is Sudden Cardiac Arrest?

- An electrical malfunction (short-circuit) causes the bottom chamber of the heart (ventricles) to beat dangerously fast (ventricular tachycardia or fibrillation) and disrupts the pumping ability of the heart.
- Occurs suddenly and often without warning
- The heart cannot pump blood to the brain, lungs and other organs of the body.
- The person loses consciousness (passes out) and has no pulse.
- Death occurs within minutes if not treated.

What causes Sudden Cardiac Arrest?

- Conditions present at birth (inherited and non-inherited heart abnormalities)
- A blow to the chest (Comotio Cordis)
- An infection/inflammation of the heart, usually caused by a virus. (Myocarditis)
- Recreational/Performance-Enhancing drug use.
- Other cardiac & medical conditions/Unknown causes. (Obesity/Idiopathic)

What are the symptoms/warning signs of Sudden Cardiac Arrest?

- Fainting/blackouts (especially during exercise)
- Dizziness
- Unusual fatigue/weakness
- Chest pain
- Shortness of breath
- Nausea/vomiting
- Palpitations (heart is beating unusually fast or skipping beats)
- Family history of sudden cardiac arrest at age < 50

ANY of these symptoms/warning signs may necessitate further evaluation from your physician before returning to practice or a game.

What are ways to screen for Sudden Cardiac Arrest?

- The American Heart Association recommends a pre-participation history and physical including 12 important cardiac elements.
- **The DIAA *Pre-Participation Physical Evaluation - Medical History* form includes ALL 12 of these important cardiac elements and is mandatory annually. Please answer the heart history questions on the student health history section of the DIAA PPE carefully.**
- Additional screening using an electrocardiogram and/or an echocardiogram is readily available to all athletes, but is not mandatory.

Where can one find additional information?

- Contact your primary care physician
- American Heart Association (www.heart.org)
- August Heart (www.augustheart.org)
- Championship Hearts Foundation (www.championshipheartsfoundation.org)
- Cypress ECG Project (www.cypresseecgproject.org)
- Parent Heart Watch (www.parentheartwatch.com)