INTERVAL HEALTH HISTORY ~ Ellicottville Central School ~ School Year _____-_____

Note: This form must be completed prior to participation in sports and is to be returned to Mrs. Watt from July 20th – August 5th.

Student Name:_____Sport:_____

Student's Date of Birth:_____Grade:_____ Sex:_____

Parent/Guardian Name:_____Address/Zip_____

Home Phone:_____Cell Phone:_____

Physician's Name:_____Physician's Phone:_____

Preferred Hospital:_____

Emergency Contact:_____Phone:_____

Date of last tetanus vaccination:_____(medical documentation required if current date is not on health record)

Participation in sports involves a certain degree of risk for injury. Such physical injury can occur in any type of sports activity and vary in nature. Athletic injuries can vary from minor injuries such as bruises and scrapes to more serious injuries such as fractures, dislocations, concussions, paralysis and even fatalities. I have carefully read and understand the questions. To the best of my knowledge there is no existing condition that should exclude my son/daughter from athletic participation. I have also received and reviewed the annexed information on concussions and their management. My signature below constitutes my permission for my child to participate in the above named sport. I understand that the district does not assume responsibility for lost or broken corrective lenses or orthodontic devices. In the event of an emergency, my signature below constitutes my permission for my child to receive medical evaluation and necessary treatment to ensure his/her health and safety. Such treatment may come from either my child's physician or another physician or medical facility as deemed appropriate by the supervising ECS staff member at his/her discretion. I appoint that ECS staff member as my Attorney In Fact to execute any necessary documents in connection with the medical treatment including any required guarantee of payment. I hereby agree to accept responsibility for medical, hospital, or physician's bills not covered by an insurance plan I may have, or the policy of the Pupil Benefits Plan, which is provided by Board of Education. I understand that my own insurance plan, if any, MUST be used before the Board's plan may be used. Pupil Benefits Plan, Inc is primary to Tri-Care, Medicaid and Child Health Plus.

PARENT/GUARDIAN SIGNATURE:_____DATE:_____

SCHOOL NURSE USE ONLY

Date of last physical exam:_____

This certifies that the above student is qualified to participate in the sport indicated above.

Date:_____School Nurse Signature:_____

NOTE: This certificate is **VOID** if pupil is absent for 5 or more consecutive days because of illness or has sustained significant injury. Health history review is required for re-entry.

If yes to any of the following questions, please explain below.

1. Sustained any injury which required medical attention; had any illnesses which lasted longer than one week or required surgery? (If YES, has the problem been fully resolved? If the problem has not been fully resolved, your child will need to be cleared by your private physician prior to participation.)	**YES**	**NO**
2. Had a convulsion (seizure)?	**YES**	**NO**
3. Had a medically diagnosed concussion?	**YES**	**NO**
4. Complained of chest pain or fainting during physical exertion?	**YES**	**NO**
5. Developed any restrictions or conditions that may be worsened by playing sports?	**YES**	**NO**
6. Been under a physician's care or taking medication now for any existing medical problem (besides routine health care)?	**YES**	**NO**
7. Developed any known allergies to medicines, foods, bee stings, etc? ***If YES, does allergy require EpiPen? YES_____ NO_____**	**YES**	**NO**
8. Has any immediate family member (sibling, parent), under fifty (50) years of age, had a history of sudden death or death due to heart disease?	**YES**	**NO**
9. Been fitted for braces? (If YES, is a mouthpiece from the orthodontist necessary?) YES_____ NO_____	**YES**	**NO**
10. Had any teeth capped or replaced artificially?	**YES**	**NO**
11. Been medically diagnosed with asthma? (If YES, an Asthma Action Plan must be completed.)	**YES**	**NO**
12. Started using contact lenses?	**YES**	**NO**
13. Other medical conditions?	**YES**	**NO**

*If you answered YES to an y of the above questions, please explain fully. Failure to provide clear, complete answers, may delay your child from beginning the sport._____

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CONCUSSION/HEAD INJURY/MILD TRAUMATIC BRAIN INJURY (MTBI) INFORMATION

Definition: A concussion is a type of traumatic brain injury (TBI), which alters the functioning of the brain. A concussion can occur with any bump, blow, or jolt to the head or body that causes the brain to quickly move back and forth. Concussions can occur as a result of a fall, motor vehicle accident, accident on the playground, during athletic participation, or during many other activities. All concussions are serious and need to be evaluated by a health care professional.

Signs & Symptoms: Look for the following signs and symptoms of a concussion for any student who has suffered a bump, blow, or jolt to their head or body:

- •Headache or head "pressure"
- •Nausea and/or vomiting
- •Dizzy and/or problems with balance
- •Blurry vision or double vision
- •Light and/or noise sensitivity
- •Feels "foggy"
- •Hard time concentrating
- •Hard time remembering
- •Confused
- •Just "don't feel right"
- •Unable to remember events before or after injury
- •Loss of consciousness
- •Appears dazed or confused

Prevention: Below are ways to help reduce the risk of sustaining a concussion:

- •Wear a seat belt every time you are driving or riding in a motor vehicle.
- •Never drive or ride in a vehicle with someone who is under the influence of drugs or alcohol.
- •Wear appropriate safety equipment, including properly fitted helmets, such as, but not limited to:
  - riding a bike, motorcycle, snowmobile, or ATV;
  - playing contact sports (examples include: football, soccer, hockey and lacrosse);
  - skiing, snowboarding, and sledding;
  - horseback riding; or
  - batting during baseball or softball.
- •During any athletic participation including practices and games:
  - always use the recommended protective equipment for that sport (all equipment should be fitted appropriately and maintained according to the manufacture's recommendations);
  - safety rules need to be followed by all participants as well as proper techniques for safe playing;
  - learn and follow the rules of the sport being played and promptly and honestly report injuries to an adult; and
  - any student with a head injury must be removed from participation, will be referred to their healthcare provided for follow-up, and will remain out of play until proper medical documentation is submitted.

Returning to Sports/Athletics: The District follows the International Consensus Conference Guidelines for Return to Play (RTP) to team sports in a monitored and graduated progression of activity over six phases once the athlete is symptom free for at least 24 hours and medically cleared by their physician*. Your physician RTP clearance is a return to our protocol, not games. The process is detailed below.

International Consensus Conference Guidelines for Return to Play Following Head Injury/Concussion:

- •**Phase 1 –** low impact, non-strenuous, light aerobic activity for short intervals, such as easy walking, biking, swimming in three 10 minute intervals with rest between; no resistance training
- •**Phase 2 –** higher impact, higher exertion activity in two 15 minute intervals, with rest in between, such as running/jumping rope, skating, or other cardio exercise; may be sports specific if available (e.g. skating without collision meaning suited up, but skating when the team is not doing drills; running without impact in soccer or football, suited up), no resistance training
- •**Phase 3 –** repeat Phase 2 progressing with shorter breaks, and add an additional 10-15 minutes stationary skill work, such as dribbling, serving, tossing a ball (balls should not be thrown or kicked in the direction of the student); low resistance training if available with spotting
- •**Phase 4 –** repeat Phase 3 without breaks in cardio, but add skill work with movement (allowing balls to be thrown/kicked in the direction of the student) and add an additional 10-15 minutes; non-contact training drills

  Student will complete post-injury ImPACT computer-based neuro-cognitive testing to compare with baseline pre-injury test results in combination with the athlete's current overall neuro-cognitive symptoms and physical presentation. Collaboration between the ATC, RN, District Physician and/or NP, and private medical provider, as needed, will determine whether to advance, hold or regress.
- •**Phase 5 –** repeat Phase 4 as a warm up; weight lifting with spotting; full contact training drills for full practice session
- •**Phase 6 –** warm up followed my full participation as tolerated

***For purposes of the head injury RTP protocol, an appropriate physician evaluation is completed by a practicing MD or DO within the following specialties: family medicine, pediatrics, sports medicine, neurology, or neurosurgery, with preference given to the individual's primary care physician. Family members and friends of the family who are medical providers may not serve as an appropriate physician. The physician completing the physician's evaluation form should document name, degree, specialty, practice name (if applicable), address, and phone number.**

For additional information on traumatic brain injuries (TBIs), please visit the following websites:

http://www.cdc.gov/concussion/HeadsUp/
http://www.cdc.gov/TraumaticBrainInjury/
http://www.health.ny.gov/prevention/injury_prevention/concussion.htm

Information adapted from the Centers for Disease Control, *Heads Up Concussion in Youth Sports,* http://edc.gov/concussion/HeadsUp/

10/2012