PARENT'S PERMISSION TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS

Division of Physical Education

Baltimore City Public Schools

_____ MO _____ DAY ____ YR. _____
NAME OF STUDENT DATE OF BIRTH

_____ _____ _____
ADDRESS IN FULL ZIP CODE PHONE NUMBER

HAS MY PERMISSION TO PARTICIPATE IN INTERSCHOLASTIC

_____ representing DUNBAR HIGH SCHOOL
Name of Sport

It is understood that HE/SHE will be permitted to participate in interscholastic athletics, only after HE/SHE has been declared physically fit by a medical doctor.

Insurance: _____

Signature of Parent
Or Legal Guardian: _____ Date: _____

Emergency Information

Emergency Contact #1

_____ _____
Parent/Guardian Name Contact Number

Emergency Contact #2

_____ _____
Parent/Guardian Contact Contact Number

Baltimore Medical System

THE HEART OF COMMUNITY HEALTH

School Health Information Form

Please help your Health Suite Staff and School Personnel keep your child safe while in school by completing this Health Registration Packet. **Please print information below.**

School Year: _____ **School Name:** _____ **Grade:** _____

Student's Name: _____ **Date of Birth:** _____ Gender: ____
Address: _____ Zip Code: _____
Race: _____ Social Security # *(needed to verify health insurance)*: _____

Parent/Guardian Name: _____
Relationship: _____Parent/Guardian Date of Birth:_____
Home #:_____ Work #:_____ Cell #:_____

Emergency Contact Information:
Name:_____ Relationship:_____ Telephone#:_____
Name:_____ Relationship:_____ Telephone#:_____

Student's Health Care Provider:
Doctor: _____ Phone:_____ Date of Last Physical: _____

Permission to Receive School Based Health Center Services:

☐ I give consent for my child to receive health services from a doctor, mental health provider or nurse practitioner on site including a well child exam. I give BMS my permission to contact my child's healthcare provider to inform him/her about my child's visit to see the provider at BMS.

Insurance information: This information is needed for visits with the medical provider. Please check one of the following below:

☐Amerigroup: Subscriber#:_____ Medicaid#:_____
☐Maryland Physicians Care: Member ID#: _____
☐United Healthcare MCO: Member ID#: _____ Payer ID: _____
☐Priority Partners: ID#: _____ Recipient#: _____
☐ Jai: Member ID#: _____
☐ MedStar Family Choice: ID#: _____ MA#_____
☐Kaiser MCO: ID#: _____
☐University of Maryland Health Partners: ID#:_____
☐Other Name: _____ ID#: _____
☐ Private Insurance Name: _____
Policy#: _____ Group#:_____
☐ No Insurance/Uninsured (If your child does not have any insurance or is uninsured please contact the health suite and we can assist you)

PLEASE TURN OVER AND COMPLETE THE BACK ➡

Baltimore Medical System

THE HEART OF COMMUNITY HEALTH

Collington Square Elementary/Middle School
Harford Heights Elementary
Mergenthaler Vocational –Technical High School
Forest Park High School
Patterson High School
Paul Laurence Dunbar High School
Tench Tilghman Elementary/Middle School
Vanguard Collegiate Middle School/ Furley Elementary School

HIPAA Privacy Practices
Patient Receipt Form
For School-Based Health

I certify that I have received from Baltimore Medical System (BMS) the Notice of Privacy Practices (NPP) describing how BMS may use and disclose my Protected Health Information (PHI). I also understand that the NPP describes my rights to access and control my protected health information.

_____ _____

Print Student's Name Name of School

_____ _____

Print Name of Parent/Guardian Signature of Parent/Guardian

_____

Date

Original to be filed in Student's File

Policy 821 Attachment C BMS 107.13 (08/17)

PLEASE RETURN COMPLETED FORM TO THE HEALTH SUITE. THANK YOU!

YOUR RIGHTS: Your rights with respect to your protected health information are below. Also included is a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains your medical and billing records. However, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. However, depending on the circumstances you may have a right to have a review of a decision to deny you access to your information. Please contact our Privacy Officer if you have questions about access to your medical record, or how to request review if you have been denied access.

You have the right to request a restriction on certain uses and disclosures of your protected health information. You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. BMS is not required to agree to a restriction that you may request. If BMS agrees to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment to you. You may request a restriction by completing the Form to Request Restrictions. Ask your Front Desk Receptionist for a copy. However, please be aware that your health information is essential to our ability to provide health care services to you. We urge you to talk to your physician before requesting a restriction on our use or disclosure of your health care information.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests to send confidential information by an alternative means or to an alternative location. For example, you may request that we communicate with you by mail rather than by phone or contact you at work rather than at your home. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures, if any, we have made of your protected health information. This right applies to disclosures we have made for purposes other than treatment, payment or health care operations. This right also excludes disclosures we made: 1) to you or to family members or friends involved in your care; 2) for notification purposes; 3) for national security or intelligence purposes; 4) to correctional institutions and law enforcement purposes; 5) for certain other purposes permitted by Federal privacy law; and 6) prior to 4/14/03. The right to receive this information is subject to certain exceptions, restrictions and limitations.

Uses and Disclosures of Protected Health Information: You will be asked by Baltimore Medical System (BMS) to sign a consent form. Once you sign the consent, BMS may use and disclose your Protected Health Information (PHI) for treatment, payment and health care operations described in this Section. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who is involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed so BMS can be paid so that services can be provided to you. Your PHI may also be used and disclosed to support the health care operations of BMS. The following examples are some of the kinds of uses and disclosures of your protected health care information that BMS and physicians may make. This is not a complete list but will illustrate the types of uses and disclosures that may be made by BMS once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as appropriate, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information to another physician or health care provider (such as a specialist or laboratory) who, at the request of your physician, becomes involved in your care.

Payment: Your protected health information will be used, as needed, to obtain payment for the health care services BMS provides to you. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you. For example, your plan may ask for information to decide whether certain services are medically necessary. For example, your plan may require that BMS disclose your relevant protected health information before it approves a hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the health care activities of BMS. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, business planning and development and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students who see patients at our facility. In addition, we may use a sign-out sheet at the registration desk where you will be asked to sign your name and time you arrived at the Center. We may also call you by name throughout the Center. We may use or disclose your protected health information, as necessary, to contact you (or your legal representative or family member) to remind you of your appointment. We will share your protected health information with third party "business associates" that perform various activities (such as, billing, transcription services) for BMS. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services available from BMS that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about the services BMS offers. We may use or disclose your demographic information and the dates that you received treatment from your physician in order to contact you for BMS fundraising activities. If you do not want to receive these materials, please contact our Privacy Officer and request that these materials not be sent to you.

PLEASE RETURN COMPLETED FORM TO THE HEALTH SUITE. THANK YOU!

Baltimore Medical System

THE HEART OF COMMUNITY HEALTH

Baltimore Medical System @ Annapolis Road
Baltimore Medical System @ St. Agnes
Belair-Edison Family Health Center
Highlandtown Healthy Living Center
Baltimore Medical System @ Orleans Square
Middlesex Health Center
School-Based Health

OUR NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY

This Notice of Privacy Practices describes how we, Baltimore Medical System, may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information that BMS creates or receives about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition, the provision of health care services to you or past, present or future payment for health care services provided to you.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of this Notice at any time. The new Notice will be effective for all protected health information that we maintain at that time. You may obtain a copy of the revised Notice of Privacy Practices by calling the Privacy Officer and requesting that a revised copy be sent to you in the mail or you may request a copy at the time of your next appointment. The revised Notice of Privacy Practices will also be posted on our website, **www.bmsi.org**.

If you have any questions about this Notice, please call 410-732-8800 and ask to speak to the Privacy Officer.

You have the right to obtain a paper copy of this notice from us upon request. To obtain a copy, please see your Front Desk Receptionist.

Rev: 08/14/12

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 _____

MARYLAND STATE DEPARTMENT OF EDUCATION
Preparing World-Class Students

For official use only:
Name of Athlete_____
Sport/season_____
Date Received_____

Concussion Awareness
Parent/Student-Athlete Acknowledgement Statement

I _____, the parent/guardian of _____,
Parent/Guardian — Name of Student-Athlete

acknowledge that I have received information on all of the following:

- The definition of a concussion
- The signs and symptoms of a concussion to observe for or that may be reported by my athlete
- How to help my athlete prevent a concussion
- What to do if I think my athlete has a concussion, specifically, to seek medical attention right away, keep my athlete out of play, tell the coach about a recent concussion, and report any concussion and/or symptoms to the school nurse.

Parent/Guardian_____ Parent/Guardian_____ Date _____
PRINT NAME — SIGNATURE

Student Athlete_____ Student Athlete_____ Date _____
PRINT NAME — SIGNATURE

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

For more information visit: **www.cdc.gov/Concussion**.

MARYLAND STATE DEPARTMENT OF EDUCATION
Preparing World-Class Students

For official use only:
Name of Athlete_____
Sport/season_____
Date Received_____

PRE-PARTICIPATION HEAD INJURY/CONCUSSION REPORTING FORM FOR EXTRACURRICULAR ACTIVITIES

This form should be completed by the student's parent(s) or legal guardian(s). It must be submitted to the Athletic Director, or official designated by the school, prior to the start of each season a student' plans to participate in an extracurricular athletic activity.

Student Information

Name:

Grade:

Sport(s):

Home Address:

Has student ever experienced a traumatic head injury (a blow to the head)? Yes_____ No_____

If yes, when? Dates (month/year): _____

Has student ever received medical attention for a head injury? Yes_____ No_____

If yes, when? Dates (month/year): _____

If yes, please describe the circumstances:

Was student diagnosed with a concussion? Yes_____ No_____

If yes, when? Dates (month/year): _____

Duration of Symptoms (such as headache, difficulty concentrating, fatigue) for most recent concussion:

Parent/Guardian: Name: _____(Please print)

Signature/Date _____

Student Athlete: Signature/Date _____

MARYLAND STATE DEPARTMENT OF EDUCATION

Preparing World-Class Students

For official use only:
Name of Athlete_____
Sport/season_____
Date Received_____

Medical Clearance for Suspected Head Injury
To be completed by a Licensed Health Care Provider (LHCP)

Directions: Provide this form to the health care provider evaluating the student's injury. Return form to school nurse immediately. If the student is diagnosed with a concussion, the form will be copied by the school nurse and the original form returned to the parent to use at the follow-up visit that clears the student for participation in athletics.

Student Name:_____

Date of Injury: _____

Initial Evaluation

Date:_____ **LHCP* Name:** _____

Signature:_____ **Phone:** _____

Diagnosis: ☐ No Concussion, may immediately resume all activities without restriction
☐ Concussion *
Date student may return to school: _____
Note: Student will be removed from all sports and physical education activities at school until medically cleared. School will implement standard academic accommodations unless specific accommodations are requested.

*** (LHCP is a Physician, Nurse Practitioner, Physician's Assistant, Neuropsychologist)**

*Follow-Up Evaluation (Required for Athletes with Concussions)

All student athletes with concussions must be medically cleared before beginning supervised Gradual Return to Sports /Physical Education Participation (RTP) program. According to COMAR 13A.06.08.01, the following licensed health care providers are permitted to authorize a student athlete to return to play:

(1) *A licensed physician trained in the evaluation and management of concussions;*
(2) *A licensed physician's-assistant trained in the evaluation and management of concussions in collaboration with the physician assistant's supervising physician or alternate supervising physician within the scope of the physician assistant's Delegation Agreement approved by the Board of Physicians;*
(3) *A licensed nurse practitioner trained in the evaluation and management of concussions;*
(4) *A licensed psychologist with training in neuropsychology and in the evaluation and management of concussions; or*
(5) *A licensed athletic trainer trained in the evaluation and management of concussions, in collaboration with the athletic trainer's supervising physician or alternate supervising physician and within the scope of the Evaluation and Treatment protocol approved by the Board of Physicians.*

I certify that I am aware of the current medical guidance on concussion evaluation and management; the above-named student-athlete has met all of the criteria for medical clearance for his/her recent concussion, and as of the date below is ready to return to a supervised Gradual Return to Sports/Physical Education Participation (RTP) program (lasting a minimum of 5 days.) Note: Students whose symptoms return during the RTP progression will be directed to stop the activity, rest until symptom free. The student will resume activity at the previous stage of the protocol that was completed without recurrence of symptoms. Students with persistent symptom return will be referred to their health care provider for evaluation.

Date:_____ **LHCP Name:** _____

Signature:_____ **Phone:** _____

[1] 2010 AAP Sport-Related Concussion in Children and Adolescents, 2008 Zurich Concussion in Sport Group Consensus.

MARYLAND STATE DEPARTMENT OF EDUCATION

Preparing World-Class Students

For official use only:
Name of Athlete_____
Sport/season_____
Date Received_____

Graduated Return to Play Protocol

Description of Stage	Date Completed	Supervised by
STAGE 1: LIGHT AEROBIC ACTIVITY Begin stage 1 when: Student is cleared by health care provider and has no symptoms Sample activities for stage 1: 20-30 minutes jogging, stationary bike or treadmill		
STAGE 2: HEAVY AEROBIC AND STRENGTH ACTIVITY Begin stage 2 when: 24 hours have passed since student began stage 1 AND student has not experienced any return of symptoms in the previous 24 hours Sample activities for stage 2: Progressive resistance training workout consisting of all of the following: • 4 laps around field or 10 minutes on stationary bike, and • Ten 60 yard springs, and • 5 sets of 5 reps: Front squats/push-ups/shoulder press, and • 3-5 laps or walking lunges		
STAGE 3: FUNCTIONAL, INDIVIDUAL SPORT-SPECIFIC DRILLS WITHOUT RISK OF CONTACT Begin stage 3 when: 24 hours have passed since student began stage 2 AND student has not experienced any return of symptoms in the previous 24 hours Sample activities for stage 3: 30-45 minutes of functional/sport specific drills coordinated by coach or athletic trainer. NOTE: no heading of soccer ball or drills involving blocking sled.		
STAGE 4: NON-CONTACT PRACTICE Begin stage 4 when: 24 hours have passed since student began stage 3 AND student has not experienced any return of symptoms in the previous 24 hours Sample activities for stage 4: Full participation in team's regular strength and conditioning program. NOTE: no heading of soccer ball or drills involving blocking sled permitted.		
STAGE 5: FULL-CONTACT PRACTICE AND FULL PARTICIPATION IN PHYSICAL EDUCATION Begin stage 5 when: 24 hours have passed since student began stage 4 AND student has not experienced any return of symptoms in the previous 24 hours Sample activities for stage 5: Unrestricted participation in practices and physical education		
STAGE 6: RETURN TO GAME Begin stage 6 when: 24 hours have passed since student began stage 5 AND student has not experienced any return of symptoms in the previous 24 hours		

MARYLAND STATE DEPARTMENT OF EDUCATION
Preparing World-Class Students

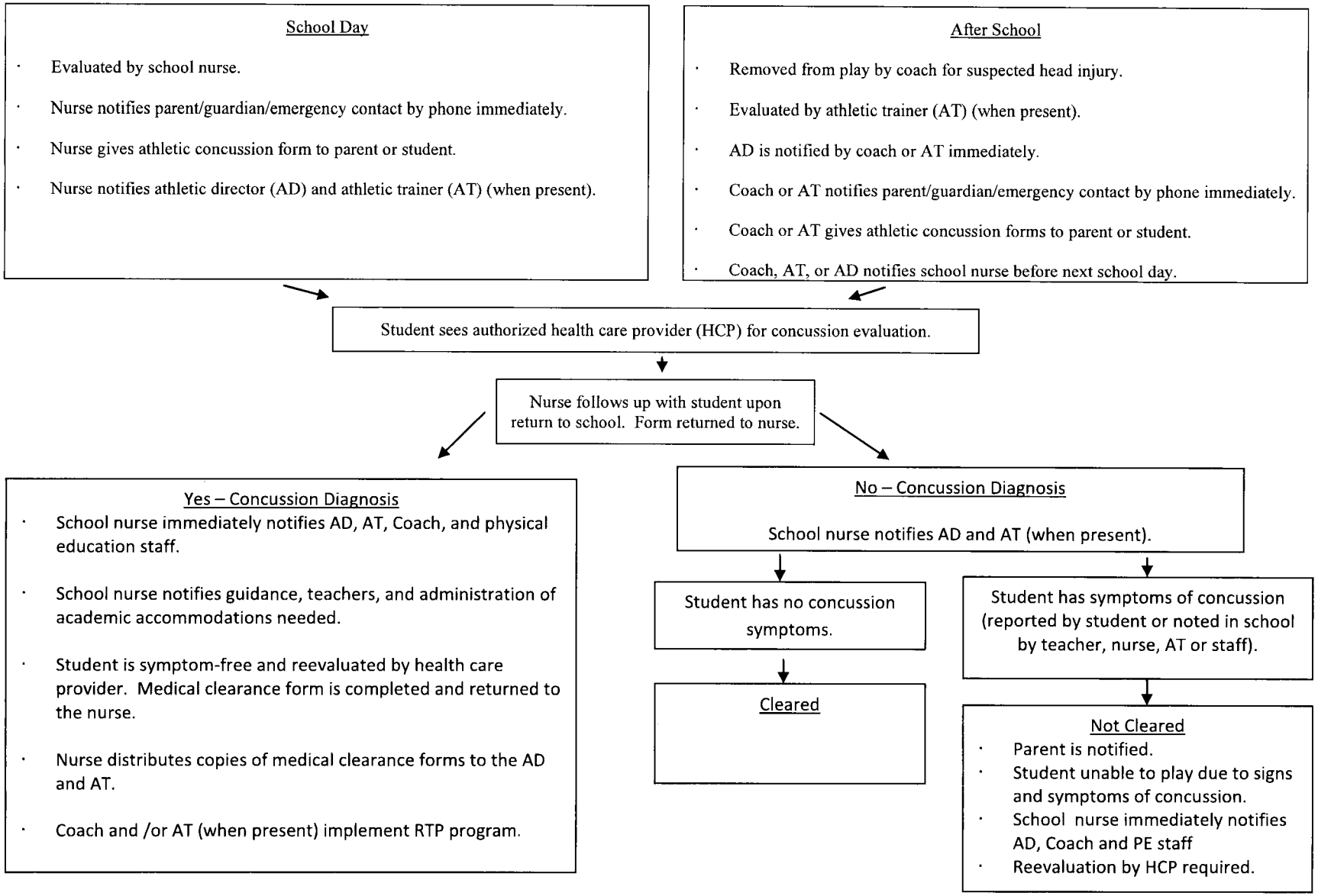
For official use only:
Name of Athlete_____
Sport/season_____
Date Received_____

Appropriate Educational Accommodations

Post-Concussion Effect	Functional School Problem	Accommodation/ Management Strategy
Attention/ Concentration	Short focus on lecture, class work, homework	Shorter assignments, break down tasks, lighter work load
"Working" Memory	Holding instructions in mind, reading comprehension, math calculation, writing	Repetition, written instructions, use of calculator, short reading passages
Memory Consolidation/ Retrieval	Retaining new information, accessing learned info when needed	Smaller chunks to learn, recognition cues
Processing Speed	Keep pace with work demand, process verbal information effectively	Extended time, slow down verbal info, comprehension-checking
Fatigue	Decreased arousal/ activation to engage basic attention, working memory	Rest breaks during classes, homework, and exams
Headaches	Interferes with concentration	Rest breaks
Light/Noise Sensitivity	Symptoms worsen in bright or loud environments	Wear sunglasses, seating away from bright sunlight or other light. Avoid noisy/ crowded environments such as lunchroom, assemblies, hallways.
Dizziness/Balance Problems	Unsteadiness when walking	Elevator pass, class transition prior to bell
Sleep Disturbance	Decreased arousal, shifted sleep schedule	Later start time, shortened day
Anxiety	Can interfere with concentration; Student may push through symptoms to prevent falling behind	Reassurance from teachers and team about accommodations; Workload reduction, alternate forms of testing
Depression/Withdrawal	Withdrawal from school or friends due to stigma or activity restrictions	Time built in for socialization
Cognitive Symptoms	Concentrating, learning	See specific cognitive accommodations above
Symptom Sensitivity	Symptoms worsen with *over*-activity, resulting in any of the above problems	Reduce cognitive or physical demands below symptom threshold; provide rest breaks; complete work in small increments until symptom threshold increases

Source: Sady, M.D., Vaughan, C.G. & Gioia, G.A. (2011) School and the Concussed Youth: Recommendations for Concussion Education and Management. *Physical Medicine and Rehabilitation Clinics of North America. 22,* 701-719. (pp.714)

High School Student-Athlete Probable Head Injury Flow Chart



MARYLAND STATE DEPARTMENT OF EDUCATION
PREPARING WORLD CLASS STUDENTS

Sudden Cardiac Arrest (SCA)
Information for Parents and Student Athletes

Definition: Sudden Cardiac Arrest (SCA) is a potentially fatal condition in which the heart suddenly and unexpectedly stops beating. When this happens, blood stops flowing to the brain and other vital organs.

SCA in student athletes is rare; the chance of SCA occurring to any individual student athlete is about one in 100,000. However, student athletes' risk of SCA is nearly four times that of non-athletes due to the increased demands on the heart during exercise.

Causes: SCA is caused by several structural and electrical diseases of the heart. These conditions predispose an individual to have an abnormal rhythm that can be fatal if not treated within a few minutes. Most conditions responsible for SCA in children are inherited, which means the tendency to have these conditions is passed from parents to children through the genes. Other possible causes of SCA are a sudden blunt non-penetrating blow to the chest and the use of recreational or performance-enhancing drugs and/or energy drinks.

Warning Signs of SCA	Emergency Response to SCA

• SCA strikes immediately.
• SCA should be suspected in any athlete who has collapsed and is unresponsive.
  o No response to tapping on shoulders
  o Does nothing when asked if he/she is OK
• No pulse
	• Act immediately; time is most critical to increase survival rates.
	• Recognize SCA.
	• Call 911 immediately and activate EMS.
	• Administer CPR.
	• Use Automatic External Defibrillator (AED).

Warning signs of potential heart issues: The following need to be further evaluated by your primary care provider.

- Family history of heart disease/cardiac arrest
- Fainting, a seizure, or convulsions during physical activity
- Fainting or a seizure from emotional excitement, emotional distress, or being startled
- Dizziness or lightheadedness, especially during exertion
- Exercise-induced chest pain
- Palpitations: awareness of the heart beating, especially if associated with other symptoms such as dizziness
- Extreme tiredness or shortness of breath associated with exercise
- History of high blood pressure

Risk of Inaction: Ignoring such symptoms and continuing to play could be catastrophic and result in sudden cardiac death. Taking these warning symptoms seriously and seeking timely appropriate medical care can prevent serious and possibly fatal consequences.

Information used in this document was obtained from the American Heart Association (www.heart.org), Parent Heart Watch (www.paretnheartwatch.org), and the Sudden Cardiac Arrest Foundation (www.sca-aware.org). Visit these sites for more information.

Frequently Asked Questions about Sudden Cardiac Arrest (SCA)

What are the most common causes of Sudden Cardiac Arrest (SCA) in a student athlete?

SCA is caused by several **structural** and **electrical** diseases of the heart. These conditions predispose an individual to have an abnormal rhythm that can be fatal if not treated within a few minutes. Most conditions responsible for SCA in children are **inherited,** which means the tendency to have these conditions is passed from parents to children through the genes. Some of these conditions are listed below.

1. *Hypertrophic cardiomyopathy (HCM):* HCM involves an abnormal thickening of the heart muscle and it is the most common cause of SCA in an athlete.
2. Coronary artery anomalies: The second most common cause is congenital (present at birth) abnormalities of coronary arteries, the blood vessels that supply blood to the heart.
3. Other possible causes of SCA are:
    a. *Myocarditis*: an acute inflammation of the heart muscle (usually due to a virus).
    b. Disorders of heart electrical activity such as:
        i. *Long QT syndrome.*
        ii. *Wolff-Parkinson-White (WPW)* syndrome.
        iii. *Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT).*
    c. *Marfan syndrome*: a condition that affects heart valves, walls of major arteries, eyes, and the skeleton.
    d. Congenital aortic valve abnormalities.
4. *Commotio Cordis*: concussion of the heart from **sudden blunt non-penetrating blow** to the chest
5. Use of recreational, **performance-enhancing** drugs, and **energy drinks** can also bring on SCA.

How can we minimize the risk of SCA and improve outcomes?

The risk of SCA in student athletes can be minimized by providing appropriate prevention, recognition, and treatment strategies. One important strategy is the requirement for a yearly pre-participation screening evaluation, often called a sports physical, performed by the athlete's medical provider.

1. It is very important that you **carefully and accurately complete the personal history and family history section** of the "Pre-Participation Physical Evaluation Form" available at http://www.mpssaa.org/HealthandSafety/Forms.asp.
2. Since the majority of these conditions are inherited, **be aware of your family history**, especially if any close family member:
    a. had sudden unexplained and unexpected death before the age of 50.
    b. was diagnosed with any of the heart conditions listed above.
    c. died suddenly /unexpectedly during physical activity, during a seizure, from Sudden Infant Death Syndrome (SIDS) or from drowning.
3. **Take seriously the warning signs and symptoms of SCA**. Athletes should notify their parents, coaches, or school nurses if they experience any of these warning signs or symptoms.
4. Schools in Maryland have AED policies and emergency preparedness plans to address SCA and other emergencies in schools. Be aware of your school's various preventive measures.
5. If a cardiovascular disorder is suspected or diagnosed based on the comprehensive pre-participation screening evaluation, a referral to a child heart specialist or pediatric cardiologist is crucial. Such athletes will be excluded from sports pending further evaluation and clearance by their medical providers.

MARYLAND STATE DEPARTMENT OF EDUCATION
PREPARING WORLD CLASS STUDENTS

For official use only:
Name of Athlete_____
Sport/season_____
Date Received_____

Parent/Student Athlete Acknowledgement Statement

Parent/Guardian

I acknowledge that I have read and understand the following:

- Sudden Cardiac Arrest (SCA) Information Sheet
- Concussion Awareness Information Sheet

_____ _____ Date _____
PRINT NAME PARENT/GUARDIAN SIGNATURE

Student Athlete

I acknowledge that I have read and understand the following:

- Sudden Cardiac Arrest (SCA) Information Sheet
- Concussion Awareness Information Sheet

_____ _____ Date _____
PRINT NAME STUDENT ATHLETE SIGNATURE

A Fact Sheet for

HIGH SCHOOL PARENTS

HEADS UP CONCUSSION

This sheet has information to help protect your teens from concussion or other serious brain injury.

What Is a Concussion?

A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move quickly back and forth. This fast movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging the brain cells.

How Can I Help Keep My Teens Safe?

Sports are a great way for teens to stay healthy and can help them do well in school. To help lower your teens' chances of getting a concussion or other serious brain injury, you should:

- Help create a culture of safety for the team.
  - › Work with their coach to teach ways to lower the chances of getting a concussion.
  - › Emphasize the importance of reporting concussions and taking time to recover from one.
  - › Ensure that they follow their coach's rules for safety and the rules of the sport.
  - › Tell your teens that you expect them to practice good sportsmanship at all times.
- When appropriate for the sport or activity, teach your teens that they must wear a helmet to lower the chances of the most serious types of brain or head injury. There is no "concussion-proof" helmet. Even with a helmet, it is important for teens to avoid hits to the head.

How Can I Spot a Possible Concussion?

Teens who show or report one or more of the signs and symptoms listed below—or simply say they just "don't feel right" after a bump, blow, or jolt to the head or body—may have a concussion or other serious brain injury.

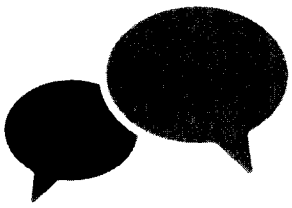
Signs Observed by Parents

- Appears dazed or stunned.
- Forgets an instruction, is confused about an assignment or position, or is unsure of the 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* or *after* a hit or fall.

Symptoms Reported by Teens

- Headache or "pressure" in head.
- Nausea or vomiting.
- Balance problems or dizziness, or double or blurry vision.
- Bothered by light or noise.
- Feeling sluggish, hazy, foggy, or groggy.
- Confusion, or concentration or memory problems.
- Just not "feeling right," or "feeling down."

Talk with your teens about concussion. Tell them to report their concussion symptoms to you and their coach right away. Some teens think concussions aren't serious or worry that if they report a concussion they will lose their position on the team or look weak. Remind them that *it's better to miss one game than the whole season.*



Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

GOOD TEAMMATES KNOW:
IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON.