Concussion History and Concussion Management Consent Form
(ALL athletes MUST complete in ink)

Name: _____ **Grade:** _____ **DOB:** _____

Fall Sport: _____ **Winter Sport:** _____ **Spring Sport:** _____

Have you ever been diagnosed with a concussion? ☐ **Yes** ☐ **No** **(Check One)**

If yes, please list the date(s) of your concussion(s): _____

_____ Total number of concussions that have resulted in loss of consciousness (blacked out)

_____ Total number of concussions that resulted in confusion

_____ Total number of concussions that resulted in difficulty remembering events that occurred immediately after injury

_____ Total number of concussions that resulted in difficulty remembering events that occurred immediately before injury

How long (approx.) did it take you to recover from EACH concussion? _____

_____

Consent for Concussion Management

I hereby give my permission for (name of student athlete) _____ to participate in the Concussion Management Program. This program may include taking a baseline neurocognitive exam prior to their athletic season. I understand that if my child suffers a suspected head injury or concussion, they will be required to see a licensed physician of medicine or osteopathic medicine (MD or DO), sufficiently familiar with current concussion management. If diagnosed with a concussion, they may be required to take a post-injury neurocognitive exam. Their symptoms may be monitored by completing daily graded symptom charts. Once cleared by their physician, they will be required to complete a step-by-step gradual progression back to physical activity and sport.

Tulpehocken Area School District may release the neurocognitive results to my child's primary care physician, neurologist, or other treating physician.

Doctor or Practice: _____ **Phone Number:** _____

I understand that general information about my child's concussion may be provided to my child's school nurse, guidance counselor, and teachers, for the purposes of providing temporary academic modifications, if necessary.

Name of parent or guardian (Please Print): _____

Signature of parent or guardian: _____

Date: _____

SECTION 5: HEALTH HISTORY – MUST BE COMPLETED IN INK

	YES	*NO (please check one)*	*PLEASE EXPLAIN (AGE / DATE IF APPLICABLE) ALL YES ANSWERS IN SPACE PROVIDED*
1)	☐Y	☐N	Has a doctor ever denied or restricted your participation in sport(s) for any reason? _____
2)	☐Y	☐N	Do you have an ongoing medical condition (like asthma or diabetes)? _____
3)	☐Y	☐N	Are you currently taking any medications (prescription or over-the-counter)? _____
4)	☐Y	☐N	Do you have allergies to medicines, pollens, foods, or stinging insects? _____
5)	☐Y	☐N	Have you ever passed out or nearly passed out DURING exercise? _____
6)	☐Y	☐N	Have you ever passed out or nearly passed out AFTER exercise? _____
7)	☐Y	☐N	Have you ever had discomfort, pain, or pressure in your chest during exercise? _____
8)	☐Y	☐N	Does your heart race or skip beats during exercise? _____
9)	☐Y	☐N	Has a doctor ever told you that you have (check all that apply and explain below): ☐High blood pressure ☐Heart murmur ☐High cholesterol ☐Heart infection _____
10)	☐Y	☐N	Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram) _____
11)	☐Y	☐N	Has anyone in your family died for no apparent reason? _____
12)	☐Y	☐N	Does anyone in your family have a heart problem? _____
13)	☐Y	☐N	Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50? _____
14)	☐Y	☐N	Does anyone in your family have Marfan syndrome? _____

Athlete's Name:_____ **Date of Birth:** _____ **Age:** _____

SECTION 5: HEALTH HISTORY (CONTINUED) – MUST BE COMPLETED IN INK

YES NO (please check one) *PLEASE EXPLAIN (AGE / DATE IF APPLICABLE) ALL YES ANSWERS IN SPACE PROVIDED*

15) ☐Y ☐N Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? _____

16) ☐Y ☐N Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise? _____

17) ☐Y ☐N Have you ever used an inhaler or taken asthma medicine? _____
18) ☐Y ☐N Is there anyone in your family who has asthma? _____
19) ☐Y ☐N Have you ever had infectious mononucleosis (mono)? _____
20) ☐Y ☐N Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? _____

21) ☐Y ☐N When exercising in the heat, do you have severe muscle cramps or become ill? _____
22) ☐Y ☐N Do you have any rashes, pressure sores, or other skin problems? _____
23) ☐Y ☐N Have you ever had a herpes skin infection? _____
24) ☐Y ☐N Have you ever spent the night in a hospital? _____
25) ☐Y ☐N Have you ever had surgery? _____

26) Have you ever injured? *[Please include side (right or left), diagnosis (i.e. sprain, fracture, dislocation, tendonitis, etc), when the injury occurred (date, age, or grade), any special treatment (surgery, metal hardware, formal PT, etc)].* **Leave blank if Not Applicable**

Neck		Chest/Ribs	
Face		Back	
Shoulder		Hip	
Upper Arm		Thigh	
Elbow		Knee	
Forearm		Shin/Calf	
Wrist		Ankle	
Hand		Foot	
Fingers		Toes	

27) ☐Y ☐N Do you regularly use a brace or get taped? _____
28) ☐Y ☐N Have you ever had a stress (overuse) fracture? _____
29) ☐Y ☐N Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? _____
30) ☐Y ☐N Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? _____
31) ☐Y ☐N Have you ever been unable to move your arms or legs after being hit or falling? _____

32) ☐Y ☐N Have you ever had a concussion or traumatic brain injury? _____
33) ☐Y ☐N Have you been hit in the head and been confused or lost your memory? _____
34) ☐Y ☐N Do you experience dizziness and/or headaches with exercise? _____
35) ☐Y ☐N Have you ever been treated for headaches or migraines? _____
36) ☐Y ☐N Have you ever had a seizure? _____

37) ☐Y ☐N Have you had any problems with your eyes or vision? _____
38) ☐Y ☐N Do you wear glasses or contact lenses? _____
39) ☐Y ☐N Do you wear protective eyewear such as goggles or a face shield? _____
40) ☐Y ☐N Do you have any problems with your hearing? _____
41) ☐Y ☐N Do you wear a hearing aid or cochlear implant? _____
42) ☐Y ☐N Do you have braces or wear a retainer? _____

43) ☐Y ☐N Are you unhappy with your weight? _____
44) ☐Y ☐N Are you trying to gain or lose weight? _____
45) ☐Y ☐N Has anyone recommended you change your weight or eating habits? _____
46) ☐Y ☐N Do you limit or carefully control what you eat? _____
47) ☐Y ☐N Do you have any concerns that you would like to discuss with a doctor? _____

FEMALES ONLY

48) ☐Y ☐N Have you ever had a menstrual period?
49) _____ How old were you when you had your first menstrual period?
50) _____ How many periods have you had in the last 12 months?
51) ☐Y ☐N Are you pregnant?

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature _____ Date _____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature _____ Date _____

SECTION 6: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER (NOT VALID UNLESS DATED BY MEDICAL EXAMINER ON OR AFTER JUNE 1, 2018)

PLEASE COMPLETE IN INK PRIOR TO PHYSICAL

Student's Name _____ Age_____ Grade_____

Enrolled in **Tulpehocken Jr / Sr High** School Sports to be played_____

Must be completed and signed by the Authorized Medical Examiner (AME) performing the herein named student's comprehensive initial pre-participation physical evaluation (CIPPE) and turned into the Principal, or the Principal's designee, of the student's school.

Height_____ **Weight**_____ **% Body Fat** (optional) _____ **Brachial Artery BP**_____/_____ (_____/_____ , _____/_____) **RP**_____

If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student's primary care physician is recommended. **Age 10-12:** BP: >126/82, RP: >104; **Age 13-15:** BP: >136/86, RP >100; **Age 16-25:** BP: >142/92, RP >96.

Vision: R 20/_____ L 20/_____ **Corrected:** YES NO (circle one) **Pupils:** Equal_____ Unequal_____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		☐ Heart murmur ☐ Femoral pulses to exclude aortic coarctation ☐ Physical stigmata of Marfan syndrome
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student's parent/guardian in Section 2 of the PIAA Comprehensive Initial Pre-Participation Physical Evaluation form:

☐ **CLEARED** ☐ **CLEARED**, with recommendation(s) for further evaluation or treatment for _____

☐ **NOT CLEARED** for the following types of sports (please check those that apply):

☐ Collision ☐ Contact ☐ Non-Contact ☐ Strenuous ☐ Moderately Strenuous ☐ Non-Strenuous

Due to _____

Recommendations(s)/Referral(s) _____

AME's Name (print/type) _____ **License #** _____

Address _____ **Phone ( )** _____

AME's Signature _____ **MD, DO, PAC, CRNP, or SNP (circle one)**

Certification Date of CIPPE _____/_____/_____

NOT VALID UNLESS DATED BY AUTHORIZED MEDICAL EXAMINER ON OR AFTER JUNE 1, 2018