Bridgeport Athletics

2018-19 Interscholastic Athletics Participation Checklist

Please read the following materials carefully. You **must** have all materials **completed, signed, verified** and in **your coach's hands before you can begin practice**. Don't wait for the last minute.

INTERSCHOLASTIC SPORTS OFFERED (1st day of Practice)

Fall Sports		Winter Sports		Spring Sports	
Conditioning-Football	8/17	Girls Basketball	11/26	Conditioning-Baseball	3/9
Football	8/23	Boys Basketball	11/29	Baseball	3/16
Boys Soccer	8/23	Wrestling	11/26	Softball	3/16
Girls Soccer	8/23	Cheerleading	11/27	Outdoor Track	3/16
Girls Volleyball	8/23				
Cheerleading	8/23				

Items Needed to Be Completed:

- □ **Permit to Participate in Interscholastic Sports (Parent Permission Form)**
- □ **Sports Physical- Valid for 13 months from date of exam**
- □ **Concussion Plan & Consent Form**
- □ **Sudden Cardiac Arrest Plan & Consent Form**
- □ **Bridgeport Academic Eligibility Requirements/Report Card**
  - For detailed eligibility information, please visit http://www.casciac.org/pdfs/eligrules070112.pdf

ALL PAPERWORK MUST BE COMPLETED & HANDED TO YOUR COACH PRIOR TO PARTICIPATION. NO EQUIPMENT WILL BE DISTRIBUTED WITHOUT A COMPLETED PACKET. ONLY COMPLETED PACKETS WILL BE ENTERED IN CIAC ROSTERS AND ALLOWED TO BEGIN PRACTICE & CONSIDERED PART OF THE TEAM.

_____/_____ _____/_____ _____

(Student Signs/Print Name) (Parent Signs/Print Name) (Date)

WARREN HARDING HIGH SCHOOL ATHLETIC DEPARTMENT

379 Bond St, Bridgeport, CT 06610 Phone: (203) 275-2751
Andrew Grasso, Director of Athletics, Email:AGrasso@bridgeportedu.net

Parental/Guardian Permission and Consent to Treat Form

Student-Athlete's Name: _____ Grade: _____

I/We give permission for the above named student-athlete to participate in organized high school athletics for Harding High School.

I/We recognize that such activities involve the potential for injury. I/We acknowledge that even with the best coaching, the use of the most advanced protective equipment and strict observance of the rules, injuries are still a possibility. On rare occasions these injuries can lead to total disability, paralysis or even death.

By signing this form below, I/We are giving our consent for the above named student athlete to attend games and/or practices where transportation is necessary.

I/We are aware that without a valid, current (within the past 13 calendar months) physical on file with the nurse's office, the above named student-athlete will not be allowed to participate in tryouts, competitions or practices.

In the event that an athletic injury or illness should occur to the above named student athlete while participating in a sanctioned athletic activity at or for Warren Harding High School, I give permission for the student athlete to receive proper/necessary care from a Certified/Licensed Athletic Trainer representing Select Medical Corporation Outpatient Division, physician or other health care provider. Furthermore, in the event that a medical emergency should occur and I cannot be contacted, I give my permission for a healthcare representative to arrange for ambulance service to the nearest medical facility. I also give permission for the staff of the medical facility to render treatment, which is considered necessary, for the student-athlete's well being and health.

I/We acknowledge that I/We have read and understand the above.

Parent/Guardian Signature:_____ Date: _____

Phone Number: _____

BRIDGEPORT PUBLIC SCHOOLS

DEPARTMENT OF ATHLETICS

PERMIT TO PARTICIPATE IN INTERSCHOLASTIC SPORTS

I/We hereby give my son/daughter *(print name)* _____ permission to participate in interscholastic athletics.

I/We acknowledge that even with the best coaching, use of appropriate protective equipment and strict observance of rules, athletic activities involve the potential for injury inherent in all sports. Injuries can at times be so severe as to result in total disability, paralysis or even death.

I/We also give permission to certified emergency personnel, hospital personnel and/or certified first aid personnel to administer treatment to my son/daughter and transport my child to the nearest hospital if required due to an injury or medial emergency.

I/We waive all claims to damages from the City of Bridgeport, Board of Education and/or its agents incurred there in.

_____ / _____

Parent's Signature Date Player's Signature Date

PLAYER is requesting permission to play in the following sport(s): _____

PLEASE LIST ALL POSSIBLE SPORTS YOU WISH TO TRYOUT/PARTICIPATE IN FOR THE 2017-18 SCHOOL YEAR OR AN ADDITIONAL COPY WILL BE REQUIRED FOR EACH NEW SPORT SEASON.

EMERGENCY INFORMATION

(Coaches must keep a copy of this form with them at all practices and games.)

Parent's Info: _____

Name Address

Legal Guardian: _____

Name Address

Parent's Phone: _____

Home Cell Work

Health Insurance/Medicaid: _____

Emergency Contact (other than parents): _____

Name Phone

Player's Date of Birth: _____ Player's Grade: _____

Player's Legal Address (if different than parent): _____

Primary Care Physician: _____

Name Phone

Hospital Preference: _____

Player's allergies and any condition for which player is being treated by a doctor or through medication: _____

_____

_____

NOTE: In accordance with CIAC requirements, student athletes can only participate in interscholastic athletics for four (4) years from the date of enrollment in 9th Grade (any school/anywhere).

DATE STUDENT ENTERED 9TH GRADE: _____ / _____ / _____

MONTH DAY YEAR

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 _____

PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

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

1. 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?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____ Weight _____	☐ Male ☐ Female	
BP ___/___ (___/___) Pulse _____	Vision R 20/_____ L 20/_____	Corrected ☐ Y ☐ 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* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)†		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic‡		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
†Consider GU exam if in private setting. Having third party present is recommended.
‡Consider 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).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ 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).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____

School Name_____

Student and Parent Concussion Informed Consent Form
2018-19

This consent form was developed to provide students and parents with current and relevant information regarding concussions and to comply with Connecticut General Statutes (C.G.S.) Chapter 163, Section 149b: *Concussions: Training courses for coaches. Education plan. Informed consent form. Development or approval by the State Board of Education* and Section 10-149c: *Student athletes and concussions. Removal from athletic activities. Notification of parent or legal guardian. Revocation of coaching permit.*

What is a Concussion?

National Athletic Trainers Association (NATA) - *A concussion is a "trauma induced alteration in mental status that may or may not involve loss of consciousness."*

Centers for Disease Control and Prevention (CDC) - *"A concussion is a type of traumatic brain injury, or TBI, caused by a bump, blow, or jolt to the head that can change the way your brain normally works. Concussions can also occur from a blow to the body that causes the head to move rapidly back and forth."* -CDC, Heads Up: Concussion http://www.cdc.gov/headsup/basics/concussion_whatis.html

Even a "ding," "getting your bell rung," or what seems to be mild bump or blow to the head can be serious" -CDC, Heads Up: Concussion Fact Sheet for Coaches http://www.cdc.gov/concussion/HeadsUp/pdf/Fact_Sheet_Coaches-a.pdf

Section 1. Concussion Education Plan Summary

The Concussion Education Plan and Guidelines for Connecticut Schools was approved by the Connecticut State Board of Education in January 2015. Below is an outline of the requirements of the Plan. The complete document is accessible on the CSDE Web site: http://www.sde.ct.gov/sde/cwp/view.asp?a=2663&q=335572

State law requires that each local and regional board of education must approve and then implement a concussion education plan by using written materials, online training or videos, or in-person training that addresses, at a minimum the following:

1. The recognition of signs or symptoms of concussion.
2. The means of obtaining proper medical treatment for a person suspected of sustaining a concussion.
3. The nature and risks of concussions, including the danger of continuing to engage in athletic activity after sustaining a concussion.
4. The proper procedures for allowing a student athlete who has sustained a concussion to return to athletic activity.
5. Current best practices in the prevention and treatment of a concussion.

Section 2. Signs and Symptoms of a Concussion: Overview

A concussion should be suspected if any one or more of the following signs or symptoms are present, or if the coach/evaluator is unsure, following an impact or suspected impact as described in the CDC definition above.

Signs of a concussion may include (i.e. what the athlete displays/looks like to an observer):

- Confusion/disorientation/irritability
- Trouble resting/getting comfortable
- Lack of concentration
- Slow response/drowsiness
- Incoherent/ slurred speech
- Slow/clumsy movements
- Loses consciousness
- Amnesia/memory problems
- Acts silly/combative/aggressive
- Repeatedly ask same questions
- Dazed appearance
- Restless/irritable
- Constant attempts to return to play
- Constant motion
- Disproportionate/inappropriate reactions
- Balance problems

Symptoms of a concussion may include (i.e. what the athlete reports):

- Headache or dizziness
- Nausea or vomiting
- Blurred or double vision
- Oversensitivity to sound/light/touch
- Ringing in ears
- Feeling foggy or groggy

State law requires that a coach MUST immediately remove a student-athlete from participating in any intramural or interscholastic athletic activity who: a) is observed to exhibit signs, symptoms or behaviors consistent with a concussion following a suspected blow to the head or body, or b) is diagnosed with a concussion, regardless of when such concussion or head injury may have occurred. **Upon removal of the athlete, a qualified school employee must notify the parent or legal guardian within 24 hours that the student athlete has exhibited signs and symptoms of a concussion.**

Section 3. Return to Play (RTP) Protocol Overview

Currently, it is impossible to accurately predict how long an individual's concussion will last. There must be full recovery before a student-athlete is allowed to resume participating in athletic activity. Connecticut law now requires that no athlete may resume participation until they have received written medical clearance from a licensed health care professional (physician, physician assistant, advanced practice registered nurse (APRN), athletic trainer) trained in the evaluation and management of concussions.

Concussion Management Requirements:

1. No athlete SHALL return to participation in the athletic activity on the same day of concussion.
2. If there is any loss of consciousness, vomiting or seizures, the athlete MUST be immediately transported to the hospital.
3. Close observation of an athlete MUST continue following a concussion. The athlete should be monitored for an appropriate amount of time following the injury to ensure that there is no worsening/escalation of symptoms.
4. Any athlete with signs or symptoms related to a concussion MUST be evaluated by a licensed health care professional (physician, physician assistant, advanced practice registered nurse (APRN), athletic trainer) trained in the evaluation and management of concussions.
5. The athlete MUST obtain an initial written clearance from one of the licensed health care professionals identified above directing her/him into a well-defined RTP stepped protocol similar to the one outlined below. If at any time signs or symptoms return during the RTP progression, the athlete should cease activity*.
6. After the RTP protocol has been successfully administered (no longer exhibits any signs or symptoms or behaviors consistent with concussions), final written medical clearance is required by one of the licensed health care professionals identified above for the athlete to fully return to unrestricted participation in practices and competitions.

Medical Clearance RTP protocol (Recommended one full day between steps)

Rehabilitation stage	Functional exercise at each stage of rehabilitation	Objective of each stage
1. No activity	Complete physical and cognitive rest until asymptomatic. School may need to be modified.	Recovery
2. Light aerobic exercise	Walking, swimming or stationary cycling maintaining intensity ,<70% of maximal exertion; no resistance training	Increase Heart Rate
3. Sport specific exercise No contact	Skating drills in ice hockey, running drills in soccer; no head impact activities	Add Movement
4. Non-contact sport drills	Progression to more complex training drills, ie. passing drills in football and ice hockey; may start progressive resistance training	Exercise, coordination and cognitive load
5. Full contact sport drills	Following final medical clearance, participate in normal training activities	Restore confidence and assess functional skills by coaching staff
6. Full activity	No restrictions	Return to full athletic participation

* If at any time signs or symptoms should worsen during the RTP progression the athlete should stop activity that day. If the athlete's symptoms are gone the next day, she/he may resume the RTP progression at the last step completed in which no symptoms were present. If symptoms return and don't resolve, the athlete should be referred back to her/his medical provider.

Section 4. Local/Regional Board of Education Policies Regarding Concussions

****** Attach local or regional board of education concussion policies ******

I have read and understand this document the "Student and Parent Concussion Informed Consent Form" and understand the severities associated with concussions and the need for immediate treatment of such injuries.

Student name: _____ **Date** _____ **Signature** _____
(Print Name)

I authorize my child to participate in _____ **for school year** _____
(Sport/Activity)

Parent/Guardian name: _____ **Date** _____ **Signature**_____
(Print Name)

References:

1. NFHS. Concussions. 2008 NFHS Sports Medicine Handbook (Third Edition). 2008: 77-82. http://www.nfhs.org. http://journals.lww.com/cjsportsmed/Fulltext/2009/05000/Consensus_Statement_on_Concussion_in_Sport_3rd.1.aspx.
2. Centers for Disease Control and Prevention. *Heads Up: Concussion in High School Sports*. http://www.cdc.gov/NCIPC/tbi/Coaches_Tool_Kit.htm.
3. CIAC Concussion Central - http://concussioncentral.ciacsports.com/

Resources:

- Centers for Disease Control and Prevention. *Injury Prevention & Control: Traumatic Brain Injury*. Retrieved on June 16, 2010. http://www.cdc.gov/TraumaticBrainInjury/index.html
- Centers for Disease Control and Prevention. *Heads Up: Concussion in High School Sports Guide for Coaches*. Retrieved on June 16, 2014.

School Name_____

Alumno y formulario de consentimiento informado de padres conmoción cerebral
2017-18

Este formulario de consentimiento fue desarrollado para proporcionar a estudiantes y padres con información actual y relevante sobre las conmociones cerebrales y cumplir con Estatutos generales de Connecticut (C.G.S.) Capítulo 163, sección 149b: *conmociones cerebrales: cursos de capacitación para entrenadores. Plan de educación. Formulario de consentimiento informado. Desarrollo o la aprobación por la Junta de educación del estado* y la sección 10-149c: *estudiantes atletas y conmociones cerebrales. Retiro de actividades atléticas. Notificación del padre o tutor legal. Revocación de coaching permiso.*

¿Qué es una conmoción cerebral?
Asociación Nacional de entrenadores atléticos (NATA) - *Una conmoción cerebral es una "alteración de trauma inducido en el estado mental que puede o no puede implicar la pérdida de la conciencia".*

Centers for Disease Control and Prevention (CDC) - *"Una conmoción cerebral es un tipo de lesión cerebral traumática, o TBI, causado por un bache, soplar o sacudir en la cabeza que puede cambiar la forma de su cerebro funciona normalmente. Conmociones cerebrales también pueden ocurrir por un golpe al cuerpo que causa la cabeza a moverse rápidamente hacia adelante y hacia atrás."* -CDC, Heads Up: conmoción cerebral http://www.cdc.gov/headsup/basics/concussion_whatis.html

Incluso un "ding", "consiguiendo su campana sonar," o lo que parece ser leve golpe o golpe en la cabeza puede ser grave " - CDC, Heads Up: concusión hoja para entrenadores http://www.cdc.gov/concussion/HeadsUp/pdf/Fact_Sheet_Coaches-a.pdf

Sección 1. Resumen de Plan de Educación de conmoción cerebral
El Plan de Educación de conmoción cerebral y directrices para las escuelas de Connecticut fue aprobado por la Junta de educación del estado de Connecticut en enero de 2015. A continuación es un resumen de los requisitos del Plan. El documento completo es accesible en el sitio Web CSDE: http://www.sde.ct.gov/sde/cwp/view.asp?a=2663&q=335572

La ley requiere que cada Consejo de educación local y regional debe aprobar y luego implementar un plan de educación conmoción cerebral mediante el uso de materiales escritos, formación online o videos o formación en la persona que dirige, como mínimo lo siguiente:

1. El reconocimiento de signos o síntomas de conmoción cerebral.
2. Los medios de obtener tratamiento médico adecuado para una persona sospechado de sufrir una conmoción cerebral.
3. La naturaleza y los riesgos de conmociones cerebrales, incluyendo el peligro de continuar a participar en la actividad atlética después de sufrir una conmoción cerebral.
4. Los procedimientos adecuados para permitir que a un estudiante atleta que ha sufrido una conmoción cerebral al regresar a la actividad atlética.
5. Prácticas actuales en la prevención y el tratamiento de una conmoción cerebral.

Sección 2. Signos y síntomas de una conmoción cerebral: Resumen
Una conmoción cerebral debe ser sospechada si uno o más de los siguientes signos o síntomas están presentes, o si no está seguro de coche/evaluador, después de un impacto o impacto sospecha como describen en la definición de la CDC anterior.

Signos de una conmoción cerebral pueden incluir (es decir, lo que el atleta muestra/similar a un observador):

- Confusión/desorientación/irritabilidad
- Problemas de descanso/conseguir cómodo
- Falta de concentración
- Respuesta lenta/somnolencia
- Discurso incoherente / mala
- Movimientos lentos/torpe
- Pierde la conciencia
- Problemas de amnesia/memoria
- Actúa tonto/combativo, agresivo
- Repetidamente preguntas mismo
- Apariencia aturdida
- Restless/irritable
- Constantes intentos de volver a jugar

- Constante movimiento
- Reacciones Disproportionate/inadecuado
- Problemas de equilibrio

Los síntomas de una conmoción cerebral pueden incluir (es decir, lo que el atleta informes):

- Dolor de cabeza o mareos
- Náuseas o vómitos
- Visión borrosa o doble
- Hipersensibilidad a la luz/sonido/touch
- Zumbido en oídos
- Sensación de niebla o aturdido

La ley requiere que un entrenador debe quitar inmediatamente un estudiante-atleta de participar en cualquier actividad atlética interescolar o intramuros del estado que: a) se observa que exhiben signos, síntomas o comportamientos coherentes con una conmoción cerebral tras un presunto golpe en la cabeza o cuerpo, o (b) es diagnosticado con una conmoción cerebral, independientemente de cuando tales lesiones de cabeza o concusión pueden haber ocurrido. **Sobre retiro del atleta, un empleado cualificado de la escuela debe notificar a los padres o tutores dentro de 24 horas que el estudiante atleta ha exhibido signos y síntomas de una conmoción cerebral.**

Sección 3. <u>Volver a jugar al Resumen de protocolo (RTP)</u>

Actualmente, es imposible predecir con exactitud cuánto durará la conmoción cerebral del individuo. Debe haber recuperación completa antes de que un estudiante atleta puedo volver a participar en la actividad atlética. Connecticut ley ahora requiere que ningún atleta puede reanudar la participación hasta que hayan recibido escrito autorización médica de un profesional médico con licencia (médico, asistente médico, enfermera de práctica avanzada (APRN), entrenador de atletismo) entrenado en la evaluación y el manejo de conmociones cerebrales.

Requisitos de la gestión de concusión:

1. Ningún atleta deberá devolver a la participación en la actividad atlética en el mismo día de la conmoción cerebral.
2. Si hay pérdida de conciencia, vómitos o convulsiones, el atleta debe transportarse inmediatamente al hospital.
3. Observación más cercana de un atleta debe continuar después de una conmoción cerebral. El atleta debe ser supervisado para una cantidad adecuada de tiempo después de la lesión para asegurarse de que no hay ningún empeoramiento/escalada de síntomas.
4. Cualquier atleta con signos o síntomas relacionados con una conmoción cerebral deben ser evaluados por un profesional médico autorizado (médico, enfermera de práctica avanzada, Asistente de médico (APRN), entrenador de atletismo) entrenado en la evaluación y el manejo de conmociones cerebrales.
5. El atleta debe obtener un <u>inicial</u> escrito separación de uno de los profesionales de salud con licencia identificados anteriormente ella dirigir en un RTP definida caminó protocolo similar al que se describe a continuación. Si en cualquier momento signos o síntomas regresan durante la progresión de la RTP, el atleta debe cesar la actividad*.
6. Protocolo después de la RTP se ha administrado con éxito (ya no exhibe ningunas muestras o síntomas o comportamientos consistentes con las conmociones cerebrales), uno de los profesionales sanitarios autorizados señalados anteriormente para que el atleta volver completamente a la participación sin restricciones en las prácticas y competiciones exija autorización médica escrita final.

Protocolo de autorización RTP médica (recomendada un día completo entre pasos)

Etapa de rehabilitación	Ejercicio funcional en cada fase de la rehabilitación	Objetivo de cada etapa
1. ninguna actividad de	Completo descanso físico y cognitivo hasta asintomático.Escuela deba modificarse.	Recuperación
2. ligero ejercicio aeróbico	Caminar, nadar o andar en bicicleta estacionaria manteniendo intensidad , < 70% del esfuerzo máximo, sin entrenamiento de resistencia	Aumentar la frecuencia cardíaca
3. deporte específico del ejercicio sin contacto	Ejercicios de patinaje en hockey sobre hielo, ejecutando simulacros en fútbol; no hay actividades de impacto principal	Agregar movimiento
4. Taladros sin contacto deporte	Progresión a la formación más complejo ejercicios, es decir. ejercicios de pases en fútbol y hockey sobre hielo;puede comenzar el entrenamiento de resistencia progresiva	Ejercicio, coordinación y carga cognitiva
5. todo deporte de contacto taladros	Tras autorización médica final, participar en actividades de formación normal	Restablecer la confianza y evaluar habilidades funcionales por coaching personal
6. Plena actividad	No hay restricciones	Volver a participación atlética completa

* Si en cualquier momento signos o síntomas deberían empeorarse durante la progresión de la RTP el atleta debe dejar actividad ese día. Si los síntomas del deportista desaparecidos al día siguiente, ella puede volver a la progresión de RTP en el último paso completada en la que no estaban presentes síntomas. Si los síntomas volver y no resolución, el atleta debe ser devuelto a su médico.

Sección 4. Locales y regionales las políticas de la Junta de educación con respecto a las conmociones cerebrales

Fijar las políticas de conmoción local o regional de educación ***

He leído y entiendo este documento"alumno y formulario de consentimiento informado de padres concusión" y entender las severidades asociadas con conmoción cerebral y la necesidad de tratamiento inmediato de estas lesiones.

Nombre del estudiante: ___ ___ fecha_ ___ firma
(Nombre en imprenta)
Autorizo a mi hijo a participar en _____ de ___ del año escolar
(Deporte/actividad)

Nombre padre/tutor: ___ ___ fecha_Signature___
(Nombre en imprenta)

Referencias:

1. NFHS. Conmociones cerebrales. Manual de medicina deportiva NFHS 2008 (tercera edición). 2008: 77-82.
   http://www.nfhs.org.
   http://journals.LWW.com/cjsportsmed/fulltext/2009/05000/Consensus_Statement_on_Concussion_in_Sport_3rd.1.aspx.
2. Centros para el Control y la prevención. *Heads Up: conmoción cerebral en los deportes de la High School secundario.* http://www.cdc.gov/NCIPC/tbi/Coaches_Tool_Kit.htm.
3. Central de la conmoción cerebral del CIAC- http://concussioncentral.ciacsports.com/

Recursos:

- Centros para el Control y la prevención. *Control y prevención de lesiones: traumatismo craneoencefálico.* Recuperado encendido 16 de junio de 2010. http://www.cdc.gov/TraumaticBrainInjury/index.html
- Centros para el Control y la prevención. *Heads Up: conmoción cerebral en la escuela secundaria guía para entrenadores de deportes.* Recuperado encendido 16 de junio de 2014.

School Name_____

Sudden Cardiac Arrest
Student & Parent Informed Consent Form
2018-19

NOTE: This document was developed to provide student-athletes and parents/guardians with current and relevant information regarding sudden cardiac arrest. A new form is required to be read, signed, dated and kept on file by the student-athlete's associated school district annually to comply with Connecticut General Statutes Chapter 163, Section 10-149f: SUDDEN CADIAC ARREST AWARENESS EDUCATION PROGRAM.

Part I – SUDDEN CARDIAC ARREST **- What is sudden cardiac arrest?**
Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens, blood stops flowing to the brain and other vital organs. SCA doesn't just happen to adults; it takes the lives of students, too. However, the causes of sudden cardiac arrest in students and adults can be different. A student's SCA will likely result from an inherited condition, while an adult's SCA may be caused by either inherited or lifestyle issues.
SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

PART II - HOW COMMON IS SUDDEN CARDIAC ARREST IN THE UNITED STATES?
SCA is the #1 cause of death for adults in this country. There are about 300,000 cardiac arrests outside hospitals each year. It is a leading cause of death for student athletes.
According to an April 2014 study for PubMed the incidence was

- 0.63 per 100,000 in all students (6 in one million)
- 1.14 per 100,000 athletes (10 in one million)
- 0.31 per student non-athletes (3 in one million)
- The relative risk of SCA in student athletes vs non-athletes was 0.65
- There is a significantly higher risk of SCA for boys than girls

Leading causes of sudden death among high school and college athletes, according to the NCAA (on CBS News, June 28, 2012)* are heat stroke, heart disease and traits associated with sickle cell anemia. Prevention of sudden death, the same study concludes, is associated with more advanced cardiac screening with attention to medical histories and birth records, improved emergency procedures, and good coaching and conditioning practices.

PART III - WHAT ARE THE WARNING SIGNS AND SYMPTOMS?
Although SCA happens unexpectedly, some people may have signs or symptoms, such as: fainting or seizures during exercise; unexplained shortness of breath; dizziness; extreme fatigue; chest pains; or racing heart.
These symptoms can be unclear in athletes, since people often confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

Sudden cardiac arrest is a medical emergency. If not treated immediately, it causes sudden cardiac death. With fast, appropriate medical care, survival is possible. Administering cardiopulmonary resuscitation (CPR) — or even just compressions to the chest — can improve the chances of survival until emergency personnel arrive. (http://www.mayoclinic.org/diseases-conditions/sudden-cardiac-arrest/basics/)

WHAT ARE THE RISKS OF PRACTICING OR PLAYING AFTER EXPERIENCING THESE SYMPTOMS?
There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who experience SCA die from it.

REMOVAL FROM PLAY
Any student-athlete who shows signs or symptoms of SCA must be removed from athletic activity and referred to a licensed health care professional trained specifically in the treatment of cardiac care. The symptoms can happen before, during or after activity.

RETURN TO PLAY

Before returning to play, the athlete must be evaluated. Clearance to return to play must be in writing. The evaluation must be performed and written clearance be provided by a licensed medical provider.

To summarize:

- SCA is, by definition, sudden and unexpected.
- SCA can happen in individuals who appear healthy and have no known heart disease.
- Most people who have SCA die from it, usually within minutes.
- Rapid treatment of SCA with a defibrillator can be lifesaving.
- Training in recognition of signs of cardiac arrest and SCA, and the availability of AEDs and personnel who possess the skills to use one, may save the life of someone who has had an SCA.

(National Heart, Lung, and Blood Institute)

I have read and understand this document the "Student & Parent Informed Consent Form" and understand the severities associated with sudden cardiac arrest and the need for immediate treatment of any suspected condition.

Student name: _____ **Date** _____ **Signature** _____
(Print Name)

I authorize my child to participate in _____ **for school year** _____
(Sport/Activity)

Parent/Guardian name: _____ **Date** _____ **Signature**_____
(Print Name)

Sources:
Simons Fund - http://www.simonsfund.org/
Pennsylvania Department of Health - http://www.simonsfund.org/wp-content/uploads/2012/06/Parent-Handout-SCA.pdf