

## **Parents and Student-Athletes:**

The 2018-2019 school year is quickly approaching and that means we are getting ready to start school sponsored activities. Every student in grades 7-12 who wishes to participate in these activities must complete a physical.

Any certified Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, Physician Assistant or Nurse Practitioner can administer this physical. They must sign these forms and it is important that you use this Physical Form that is recognized by the SDHSAA. Other physical forms will not be accepted.

The following packet must be completed to entirety and returned to the Chamberlain School District prior to participation in any of our school sponsored activities. This packet includes the following forms:

1. Annual Parental Permit Form
2. Pre-Participation History Form
3. Release of Medical Information Form (HIPAA)
4. Concussion Fact Sheet for Athletes
5. Concussion Fact Sheet for Parents
6. Physical Form and Instructions
7. Parent and Student Consent Form/Medical Consent Form
8. Insurance Information
9. Activities Handbook Agreement (Handbook can be found on our school websites)

This packet, as well as the Activities Handbook, will be made available on the CSD website and also available in the Highschool Office. Again, these forms are a requirement to participate. If you have questions, please contact me at [Danny.Hutcheson@k12.sd.us](mailto:Danny.Hutcheson@k12.sd.us).

Enjoy the rest of your Summer!

Sincerely,

*Danny Hutcheson*

**Activities Director Chamberlain School District**

**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION**

**PHYSICAL EXAMINATION  
ITEMS TO BE EVALUATED**

**Station 1 - Individual History**

All YES items in the history are reviewed in detail to determine if they constitute a risk to participation by the athlete, or need additional evaluation.

**Station 2 - Blood Pressure**

Right arm, sitting. Values needing recheck and possible further evaluation are:

Under 11 Years 130/75  
12 years and older 140/85

**Station 3 - Vision (Snellen)**

Uncorrected vision less than 20/200, corrected vision less than 20/40 requires further evaluation.

**Station 4 - Skin, Mouth, Eyes, Ears**

Pustular acne, herpes or other infections, athlete's foot; braces, dental prostheses, severe caries, pupil inequality, contacts; ear drainage, malformation.

**Station 5 - Chest**

Review of cardiac-related history. Heart enlargement, pulse discrepancy, murmurs, abnormal rhythm, forced expiratory maneuver, evidence of latent bronchospasm.

**Station 6 - Lymphatics, Abdomen, Genitalia**

Cervical or axillary adenopathy, organomegaly, absence of testicles, and hernia (males only).

**Station 7 - Orthopedic**

Asymmetry, scoliosis, swelling or deformity, decreased range of motion or strength

**Station 8 - Review**

**CLEARANCE**

- \_\_\_\_\_ Cleared for ALL (*collision, contact/endurance sports, and other sports*)
- \_\_\_\_\_ Cleared only for *contact/endurance sports* and *other sports*
- \_\_\_\_\_ Cleared only for *other sports*

Definition: [Collision=Football and Wrestling]; [Contact/Endurance Sports=Basketball, Cross Country, Gymnastics, Soccer, Tennis, Track, Volleyball, Competitive Cheer and Competitive Dance]; [Other Sports=Golf]

- \_\_\_\_\_ Cleared for ALL, but with recommendations for further evaluation or treatment for \_\_\_\_\_
- \_\_\_\_\_ Above clearance to be granted only after \_\_\_\_\_
- \_\_\_\_\_ Clearance cannot be given at this time because \_\_\_\_\_

**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION  
ORTHOPEDIC SCREENING GUIDE**

<b>Athletic Activity (Instructions)</b>	<b>Observation</b>
Stand Facing Examiner	General habitus; acromioclavicular joints
Look at ceiling, floor, over both shoulders: touch ears to shoulders	Cervical spine motion
Shrug shoulders (examiner resists)	Trapezius strength
Abduct shoulder 90 degrees (examiner resists at 90 degrees)	Deltoid strength
Full external rotation of arms	Shoulder motion
Flex and extend elbows	Elbow motion
Arms at sides, elbow 90 degrees flexed, pronate and supinate wrists	Elbow and wrist motion
Spread fingers; make fist	Hand or finger motion and deformities
Tighten (contact) quadriceps; relax quadriceps	Symmetry and knee effusion; ankle effusion
"Duck walk" four steps (away from the examiner with buttocks on heels)	Hip, knee and ankle motion
Back to examiner; knees straight, touch toes	Shoulder symmetry; scoliosis, hip motion, hamstring tightness
Raise up on toes, raise heels	Calf symmetry, leg strength

**May require reflex hammer, tape measure, pin, and examination table.**

## INTERIM PRE-PARTICIPATION HISTORY

(Used in conjunction with the Biennial/Triennial examination.)

NAME: \_\_\_\_\_ GRADE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
 (2018-19 School Year)

### IN THE PAST YEAR:

YES NO

		YES	NO
1.	Has a doctor denied your participation in sports for any reason?		
2.	Do you have a new ongoing medical condition (like diabetes or asthma)?		
3.	Are you currently taking any new prescription or non-prescription (over-the-counter) medicines or pills?		
4.	Do you have new allergies to medicines, pollens, foods, or stinging insects?		
5.	Have you passed out or nearly passed out DURING exercise?		
6.	Have you passed out or nearly passed out AFTER exercise?		
7.	Have you had discomfort, pain, or pressure in your chest during exercise?		
8.	Has your heart raced or skipped beats during exercise?		
9.	Has a doctor told you that you have a heart murmur, high blood pressure, high cholesterol, or a heart infection?		
10.	Has a doctor ordered a test for your heart? (for example: ECG, echocardiogram)		
11.	Has anyone in your family died for no apparent reason?		
12.	Have you spent the night in a hospital?		
13.	Have you had surgery?		
14.	Have you had an injury, like a sprain, muscle or ligament tear, or tendonitis, that required medical attention?		
15.	Have you had any broken or fractured bones or dislocated joints?		
16.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?		

YES NO

17.	Have you had a stress fracture?		
18.	Did a doctor tell you that you have asthma or allergies?		
19.	Have you started to cough, wheeze, or have difficulty breathing during or after exercise?		
20.	Have you used an inhaler or taken asthma medicine?		
21.	Have you lost a kidney, an eye, a testicle, or any other organ?		
22.	Do you have any new rashes, pressure sores, or other skin problems?		
23.	Have you had a new herpes skin infection?		
24.	Have you had a head injury or concussion?		
25.	Have you been hit in the head and been confused or lost your memory?		
26.	Have you had a seizure?		
27.	Have you experienced headaches with exercise?		
28.	Have you had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
29.	Have you been unable to move your arms or legs after being hit or falling?		
30.	When exercising in the heat, did you have severe muscle cramps or become ill?		

Explain "Yes" answers here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(continue on front side of this form if necessary)

## RECERTIFICATION OF HEALTH

As the parent/guardian, I herewith affix my signature and certify that the above-named student is physically fit to participate in interscholastic athletics for the current school year insofar as all "Yes" responses are concerned.

\_\_\_\_\_, 20\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Parent

# 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	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
<b>HEART HEALTH QUESTIONS ABOUT YOU</b>	<b>Yes</b>	<b>No</b>	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
<b>HEART HEALTH QUESTIONS ABOUT YOUR FAMILY</b>	<b>Yes</b>	<b>No</b>	39. Have you ever been unable to move your arms or legs after being hit or falling?		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			40. Have you ever become ill while exercising in the heat?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
<b>BONE AND JOINT QUESTIONS</b>	<b>Yes</b>	<b>No</b>	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			<b>FEMALES ONLY</b>		
25. Do you have any history of juvenile arthritis or connective tissue disease?			52. Have you ever had a menstrual period?		
			53. How old were you when you had your first menstrual period?		
			54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

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SOUTH DAKOTA HIGH SCHOOL
ACTIVITIES ASSOCIATION
PHYSICAL EXAMINATION FORM

Date Exam Expires: \_\_\_\_\_

Check Appropriate Physical Exam Term:
Annual Biennial Triennial

NAME \_\_\_\_\_ GRADE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

CHECK ONE: MALE FEMALE (2018-19 School Year)

1. Blood pressure (sitting) \_\_\_\_ / \_\_\_\_ Repeat in 5 minutes, if elevated \_\_\_\_ / \_\_\_\_.

2. Height \_\_\_\_\_

3. Weight \_\_\_\_\_

Normal Abnormal COMMENTS

4. Vision 20/\_\_\_\_ (L) 20/\_\_\_\_ (R) \_\_\_\_\_

5. Head \_\_\_\_\_

6. Mouth (dentures, braces?) \_\_\_\_\_

7. Eyes (contacts?) \_\_\_\_\_

8. Chest/lung \_\_\_\_\_

9. Heart \_\_\_\_\_

a. Heart sounds \_\_\_\_\_

b. Murmurs \_\_\_\_\_

c. pulse (rad. vs fem.) \_\_\_\_\_

d. rhythm \_\_\_\_\_

10. Abdomen \_\_\_\_\_

a. liver or spleen \_\_\_\_\_

b. masses \_\_\_\_\_

11. Genitalia (males only) \_\_\_\_\_

a. hernias \_\_\_\_\_

b. testes \_\_\_\_\_

12. Orthopedic \_\_\_\_\_

a. cervical spine \_\_\_\_\_

b. shoulder shrug \_\_\_\_\_

c. deltoid \_\_\_\_\_

d. arms/elbow \_\_\_\_\_

e. hands \_\_\_\_\_

f. hips \_\_\_\_\_

g. knees \_\_\_\_\_

h. ankles \_\_\_\_\_

i. Scoliosis \_\_\_\_\_

SPORTS PARTICIPATION RECOMMENDED FOR:

\_\_\_\_\_ Cleared for ALL (collision, contact/endurance sports, and other sports)

\_\_\_\_\_ Cleared only for contact/endurance sports and other sports

\_\_\_\_\_ Cleared only for other sports

Definition: [Collision=Football and Wrestling]; [Contact/Endurance Sports=Basketball, Cross Country, Gymnastics, Soccer, Tennis, Track, Volleyball, Competitive Cheer and Competitive Dance]; [Other Sports=Golf]

\_\_\_\_\_ Cleared for ALL, but with recommendations for further evaluation or treatment for \_\_\_\_\_

\_\_\_\_\_ Above clearance to be granted only after \_\_\_\_\_

\_\_\_\_\_ Clearance cannot be given at this time because \_\_\_\_\_

NAME OF EXAMINER (PRINT) \_\_\_\_\_ DATE \_\_\_\_\_, 20 \_\_\_\_\_

SIGNATURE OF EXAMINER \_\_\_\_\_

NOTE: The following licensed medical personnel are qualified to perform the examination and certify the health of the student athlete: Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, licensed Physician Assistant and licensed Nurse Practitioner.

**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION  
ANNUAL PARENT AND STUDENT CONSENT FORM**

School Year: 2018-2019 Name of High School: \_\_\_\_\_

Name of Student: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

The Parent and Student hereby:

1. Understand and agree that participation in SDHSAA sponsored activities is voluntary on the part of the student and is considered a privilege.
2. Understand and agree that (a) by this Consent Form the SDHSAA has provided notification to the parent and student of the existence of potential dangers associated with athletic participation; (b) participation in any athletic activity may involve injury of some type; (c) the severity of such injuries can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries such as injuries to the body's bones, joints, ligaments, tendons, or muscles. Catastrophic injuries to the head, neck and spinal cord and concussions may also occur. On rare occasions, injuries so severe as to result in total disability, paralysis and death; and (d) even with the best coaching, use of the best protective equipment, and strict observance of rules, injuries are still a possibility.
3. Consent and agree to participation of the student in SDHSAA activities subject to all SDHSAA bylaws and rules interpretations for participation in SDHSAA sponsored activities, and the activities rules of the SDHSAA member school for which the student is participating; and
4. Consent and agree that personally identifiable directory information may be disclosed about the student as a result of his/her participation in SDHSAA sponsored activities. Such directory information may include, but is not limited to, the student's photograph, name, grade level, height, weight, and participation in officially recognized activities and sports. *If I do not wish to have any or all such information disclosed, I must notify the above mentioned high school, in writing, of our refusal to allow disclosure of any or all such information prior to the student's participation in sponsored activities.*

I acknowledge that I have read paragraphs one (1) through four (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participating in activities.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Name of Student (Print Name) Student Signature

I am the student's parent/guardian. I acknowledge that I have read paragraphs (1) through (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities. I hereby give my permission for \_\_\_\_\_ (student's name) to practice and compete for the above named high school in activities approved by the SDHSAA.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian (Print Name) Parent/Guardian Signature

**THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR  
INSPECTION AT THE SCHOOL**

**CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM (HIPAA)**

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. I authorize the use or disclosure of the above-named individual's health information including the Initial and Interim Pre-Participation History and Physical Exam information pertaining to a student's ability to participate in South Dakota High School Activities Association sponsored activities. Such disclosure may be made by any Health Care Provider generating or maintaining such information.
2. The information identified above may be used by or disclosed to the school nurse, athletic trainer, coaches, medical providers and other school personnel involved in the care of this student.
3. This information for which I am authorizing disclosure will be used for the purpose of determining the student's eligibility to participate in extracurricular activities, any limitations on such participation and any treatment needs of the student.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the school administration. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. This authorization will expire on July 1, 2019.
6. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
7. I understand authorizing the use or disclosure of the information identified above is voluntary. However, a student's eligibility to participate in extracurricular activities depends on such authorization. I need not sign this form to ensure healthcare treatment.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Student (If Over 18)

\_\_\_\_\_  
Date

**This form must be completed annually and must be available for inspection at the school**



## CONCUSSION FACT SHEET FOR ATHLETES

### *What is a concussion?*

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body
- Can change the way your brain normally works
- Can occur during practices or games in any sport or recreational activity
- Can happen even if you haven't been knocked out
- Can be serious even if you've just been "dinged" or "had your bell rung"

All concussions are serious. A concussion can affect your ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most people with a concussion get better, but it is important to give your brain time to heal.

### *What are the symptoms of a concussion?*

You can't see a concussion, but you might notice one or more of the symptoms listed below or that you "don't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

### *What should I do if I think I have a concussion?*

- **Tell your coaches and your parents.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach right away if you think you have a concussion or if one of your teammates might have a concussion.
- **Get a medical check-up.** A doctor or other health care professional can tell if you have a concussion and when it is OK to return to play.
- **Give yourself time to get better.** If you have a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have another concussion. Repeat concussions can increase the time it takes for you to recover and may cause more damage to your brain. It is important to rest and not return to play until you get the OK from your health care professional that you are symptom-free.

### *How can I prevent a concussion?*

Every sport is different, but there are steps you can take to protect yourself.

- Use the proper sports equipment, including personal protective equipment. In order for equipment to protect you, it must be:
  - The right equipment for the game, position, or activity
  - Worn correctly and the correct size and fit
  - Used every time you play or practice
- Follow your coach's rules for safety and the rules of the sport
- Practice good sportsmanship at all times

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

Student's Name (please print) \_\_\_\_\_ Date: \_\_\_\_\_

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**THIS FORM MUST BE SIGNED ANNUALLY AND MUST BE AVAILABLE FOR  
INSPECTION AT THE SCHOOL**

## CONCUSSION FACT SHEET FOR PARENTS

### *What is a concussion?*

A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even or what seems to be a mild bump or blow to the head can be serious.

### *What are the signs and symptoms?*

You can't see a concussion, Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports, one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

Signs Observed By Parents or Guardians	Symptoms Reported by Athlete
<ul style="list-style-type: none"> <li>• Appears dazed or stunned</li> <li>• Is confused about assignment or position</li> <li>• Forgets an instruction</li> <li>• Is unsure of game, score, or opponent</li> <li>• Moves clumsily</li> <li>• Answers questions slowly</li> <li>• Loses consciousness (even briefly)</li> <li>• Shows mood, behavior, or personality changes</li> <li>• Can't recall events prior to hit or fall</li> <li>• Can't recall events after hit or fall</li> </ul>	<ul style="list-style-type: none"> <li>• Headache or "pressure" in head</li> <li>• Nausea or vomiting</li> <li>• Balance problems or dizziness</li> <li>• Double or blurry vision</li> <li>• Sensitivity to light or noise</li> <li>• Feeling sluggish, hazy, foggy, or groggy</li> <li>• Concentration or memory problems</li> <li>• Confusion</li> <li>• Just not "feeling right" or is "feeling down"</li> </ul>

### *How can you help your teen prevent a concussion?*

Every sport is different, but there are steps your teens can take to protect themselves from concussion and other injuries.

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport
- Encourage them to practice good sportsmanship at all times.

### *What should you do if you think your teen has a concussion?*

1. **Keep your teen out of play.** If your teen has a concussion, her/his brain needs time to heal. Don't let your teen return to play the day of the injury and until a health care professional, experienced in evaluating for concussion, says your teen is symptom-free and it's OK to return to play. A repeat concussion that occurs before the brain recovers from the first – usually within a short period of time (hours, days, or weeks) – can slow recovery or increase the likelihood of having long-term problems. In rare cases, repeat concussions can result in edema (brain swelling), permanent brain damage, and even death.
2. **Seek medical attention right away.** A health care professional experienced in evaluating for concussion will be able to decide how serious the concussion is and when it is safe for your teen to return to sports.
3. **Teach your teen that it's not smart to play with a concussion.** Rest is key after a concussion. Sometimes athletes wrongly believe that it shows strength and courage to play injured. Discourage others from pressuring injured athletes to play. Don't let your teen convince you that s/he's "just fine".
4. **Tell all of your teen's coaches and the student's school nurse about ANY concussion.** Coaches, school nurses, and other school staff should know if your teen has ever had a concussion. Your teen may need to limit activities while s/he is recovering from a concussion. Things such as studying, driving, working on a computer, playing video games, or exercising may cause concussion symptoms to reappear or get worse. Talk to your health care professional, as well as your teen's coaches, school nurse, and teachers. If needed, they can help adjust your teen's school activities during her/his recovery.

Parent/Guardian's Name (Please print) \_\_\_\_\_ Date \_\_\_\_\_, 20\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_, 20\_\_\_\_

**THIS FORM MUST BE SIGNED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL**

**SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION  
ANNUAL PARENT OR GUARDIAN PERMIT**

I hereby give my consent for \_\_\_\_\_ GRADE \_\_\_\_\_  
Name (Please Print) 2018-19 School Year

who was born at \_\_\_\_\_  
City, Town, County, State

on \_\_\_\_\_ to compete in SDHSAA approved athletics for \_\_\_\_\_ High School  
Date of Birth

during the 2018-19 school year.

I/We give our permission for our son/daughter to participate in organized high school athletics, realizing that such activity involves the potential for injury which is inherent in all sports.

Date \_\_\_\_\_, 20\_\_\_\_ Signed \_\_\_\_\_  
Parent or Legal Guardian

**THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL.**

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**CONSENT FOR MEDICAL TREATMENT**

I am the **PLEASE CIRCLE ONE** Mother Father Legal Guardian of \_\_\_\_\_  
\_\_\_\_\_, who participates in co-curricular activities for \_\_\_\_\_

\_\_\_\_\_ High School. I hereby consent to any medical services that may be required while said child is under the supervision of an employee of the \_\_\_\_\_ School District while on a school-sponsored activity and hereby appoint said employee to act on behalf in securing necessary medical services from any duly licensed medical provider.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Parent(s)/Legal Guardian Signature: \_\_\_\_\_

**CONSENT OF CHILD**

I, \_\_\_\_\_, have read the above Consent For Medical Treatment Form signed by my (**PLEASE CIRCLE ONE**) Mother Father Legal Guardian and join with (**PLEASE CIRCLE ONE**) him her in the consent.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Student's Signature: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Insurance Carrier's Phone Number: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Alerts:

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**CHAMBERLAIN SCHOOL DISTRICT 7-1  
FINE ARTS AND ATHLETIC TRAINING RULES  
PARTICIPANT AGREEMENT STATEMENT**

**NAME OF STUDENT** \_\_\_\_\_

WE AS A PARTICIPANT AND PARENT OR GUARDIAN HAVE READ AND UNDERSTOOD THE CONTENTS AND PROVISIONS OF THE TRAINING RULES OF THE CHAMBERLAIN SCHOOL DISTRICT.

AS PARENTS OR GUARDIANS WE PLEDGE TO ENCOURAGE OUR SON/DAUGHTER TO PRACTICE AND PERFORM TO THE BEST OF HIS/HER ABILITY WHILE MAINTAINING A BASIC GOOD ATTITUDE TOWARDS THEIR ACTIVITY. WE GRANT OUR PERMISSION FOR THEM TO PARTICIPATE IN FINE ARTS PROGRAMS AND ATHLETIC EVENTS.

WE AS PARTICIPANT AND PARENT OR GUARDIAN ACCEPT THE PROVISIONS OF THE RULES AND REGULATIONS OF CHAMBERLAIN SCHOOL DISTRICT 7-1 AND THOSE OF THE SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION.

DATE \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PARTICIPANT

\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN