



Checklist for Participation in Athletics

Dear Parent/Guardian,

Enclosed you will find the documentation required in order for your child to participate in middle school and high school athletics in Richland School District Two. Please read this information completely, and feel free to contact the athletics department at your child's school should you have any questions or concerns. All forms must be completed prior to participation in any athletics related activity. This includes but is not limited to tryouts, conditioning, weightlifting, practice, matches, meets, events, or games.

Please use the following checklist as a guideline to ensure your child's participation in athletics is not delayed.

Middle & High School Sports

- _____ Sports Health & Participation Form - Includes Concussion Information Acknowledgement (Concussion Fact Sheets must be reviewed by parents and athletes prior to signing this form.)
- _____ SCHSL Physical form (2 pages).
**History completed thoroughly and accurately, athlete marked as "cleared" and physical signed by an MD, DO, PA, or NP, dated after April 1 of the previous school year. Preferably an original document.*
- _____ **Copy** of Birth Certificate turned in to Athletic Director.
**Submitted one time to verify student's age.*
- _____ Athletic Participation Fee \$50.00
**Paid once per school year regardless of number of sports played (covers all 3 seasons).*

Special Forms – Check with the school's Athletic Director to determine specific requirements.

- _____ Transfer Forms (*New students to the school.*)
- _____ Middle School Eligibility Form –or– Middle School Waiver Form
(*MS playing HS sports – submitted each semester – see HS AD for requirements*)

COMPLETING THE RICHLAND TWO PHYSICALS PACKET

Paperwork must meet the following MINIMUM criteria for an athlete to be cleared:

Athlete information completed.

■ 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) _____

Medications 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:
☐ Medication ☐ Pollen ☐ 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"/> Diabetes <input type="checkbox"/> Infection <input type="checkbox"/> Other _____			27. Have you ever used an inhaler or taken asthma medication?		
3. Have you ever had the shingles in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. When you were without or are you missing a kidney, an eye, a testicle, stomach, your spleen, or any other organ?		
5. Have you ever had a heart problem? If so, describe it and how you feel about it.			30. Do you have any scars or a visible bulge or hernia in the groin area?		
6. Have you ever had a heart problem? If so, describe it and how you feel about it.			31. Have you had a heart attack or stroke within the last month?		
7. Have you ever had a heart problem? If so, describe it and how you feel about it.			32. Have you ever had a heart problem? If so, describe it and how you feel about it.		
8. Have you ever had a heart problem? If so, describe it and how you feel about it.			33. Have you ever had a heart problem? If so, describe it and how you feel about it.		
9. Have you ever had a heart problem? If so, describe it and how you feel about it.			34. Have you ever had a heart problem? If so, describe it and how you feel about it.		
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24. Have you ever had a heart problem? If so, describe it and how you feel about it.			49. Have you ever had a heart problem? If so, describe it and how you feel about it.		
25. Have you ever had a heart problem? If so, describe it and how you feel about it.			50. Have you ever had a heart problem? If so, describe it and how you feel about it.		

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 _____

Athlete Signature

Parent Signature

Date

■ PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS
1. Consider additional questions on exam completion below:
• Do you feel drowsy or out of control a lot of times?
• Do you ever feel sad, hopeless, depressed, or anxious?
• Do you feel safe at your home or residence?
• Have you ever had a fight, argument, or conflict with anyone?
• During the past 30 days, did you use any weapons, knives, or drugs?
• Do you drink alcohol or use any other drugs?
• Have you ever taken medical treatment or used any other performance products?
• Have you ever taken any supplements to help you gain or lose weight or improve your performance?
• Do you ever use a seat belt, car seat, or child seat?
2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION	Normal	Abnormal
Height _____ Weight _____ Blood pressure _____ Heart rate _____		
General appearance (skin, hair, eyes, ears, nose, mouth, throat, neck, chest, abdomen, back, extremities)		
Neck		
Heart		
Lungs		
Abdomen		
Extremities		
Neurological		
Back		
Shoulders		
Elbows		
Wrists/hands		
Feet		
Legs		
Genitals		
Rectum		
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■ 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please identify specific allergy below.	
<input type="checkbox"/> Medicines	<input type="checkbox"/> Pollens <input type="checkbox"/> Food <input type="checkbox"/> 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: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <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: _____		
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

PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

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

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

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider 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

RICHLAND DISTRICT 2 SPORTS HEALTH FORM

Please print clearly. Please do not leave any blanks (mark "n/a" as appropriate).

Last Name _____ First Name _____ MI _____ Date of Birth ____/____/____
RSD2 Email _____@richland2.org School Year _____ - _____ Grade _____ Age _____ Sex _____
Mailing Address _____ City _____ Zip _____
Athlete's Cell # (____) _____ - _____ Home # (____) _____ - _____ Personal Email _____
Family Doctor _____ Phone # (____) _____ - _____ Family Dentist _____ Phone # (____) _____ - _____
Family Orthopedist _____ Phone # (____) _____ - _____ Preferred Hospital _____
Guardian Name _____ Relation: _____ Cell # (____) _____ - _____ Work # (____) _____ - _____
Guardian Name _____ Relation: _____ Cell # (____) _____ - _____ Work # (____) _____ - _____
Emergency Contact Name (other than parent/guardian) _____ Relation to Athlete _____
Home # (____) _____ - _____ Cell # (____) _____ - _____ Work # (____) _____ - _____ Other # (____) _____ - _____

PERMISSION TO PARTICIPATE, ASSUMPTION OF RISK, SECONDARY INSURANCE ACKNOWLEDGEMENT

As the parent or legal guardian of the above named student-athlete, I/we give my permission for his/her participation in athletic activities and pre-participation physical evaluation (PPE) by a physician, physician's assistant, or nurse practitioner for that participation. I/We understand that the PPE is simply a screening evaluation and not a substitute for regular healthcare. I/We know that the risk of injury/illness to my child comes with participation in sports and during travel to/from activities. I/We have had the opportunity to understand the risk of injury during participation in sports through meetings, written information, or by some other means and give my/our permission to participate in interscholastic athletics. Richland School District 2 carries athletic accident insurance on all its athletes, intended to be an "excess" policy designed to pay after the athlete's primary health insurance. In the event of injury, while participating as a part of a SCHSL sanctioned sports team representing RSD2, the athlete should seek the attention of their school's Sports Medicine staff as soon as possible. A staff member will fill out the top portion of the insurance claim form. The parent/guardian should complete the remainder of the form, follow the attached directions, and mail the completed form to the insurance company. Medical care must be initiated within 60 days, and forms must be submitted directly to AIG Insurance Company by the PARENT within 90 days of the date of injury to be eligible for coverage. RSD2 or its schools cannot be held responsible for the financial or other costs associated with injuries sustained while participating in athletics.

RELEASE OF MEDICAL INFORMATION

I/We grant permission to Nurses, Certified Athletic Trainers, Coaches, Physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to all necessary medical information. I/We grant the school's Sports Medicine staff access to medical information concerning my son/ daughter by a physician or their staff. Likewise, the school's Sports Medicine staff may release medical information to Physician's offices, Coaches, Nurses, Administrators, and school/district Faculty/Staff.

CONCUSSION ACKNOWLEDGEMENT

I have received and understood information in some means regarding concussions and brain injury, which has informed me of the nature and risk of concussion and brain injury, including the risks associated with continuing to participate in physical activity after a concussion or brain injury. I understand that any symptom(s) of concussion should be reported to my child's coach immediately, and that my child should not participate in any physical activity, driving of a motor vehicle, or strenuous mental activity until evaluated for concussion and cleared by an appropriate healthcare provider (physician, athletic trainer, physician assistant, or nurse practitioner). If diagnosed with a concussion, I understand that my child must be symptom free, cleared by a licensed physician, and complete a gradual return to play protocol supervised by a qualified medical professional prior to resuming physical activity in accordance with South Carolina State Law. It is highly recommended that the clearing physician be specifically trained in the management of sports related concussion.

CONSENT FOR MEDICAL TREATMENT

I/We give consent for Certified Athletic Trainers and Coaches to use their own judgment in either providing or securing medical care or ambulance service during a medical emergency, when a parent/guardian cannot be reached. Furthermore, I/we give permission for our son/daughter to receive medical care, without explicit parental notification, from the school's Sports Medicine staff and/or Team Physicians if he/she becomes injured while participating in athletics.

By signing below, I attest that the provided information is correct, and that I understand and agree to the statements above regarding Permission to Participate, Assumption of Risk, Secondary Insurance Acknowledgement, Release of Medical Information, Concussion Acknowledgement, and Consent for Medical Treatment. I/We commit to reporting ALL injuries and illnesses to the Sports Medicine staff, especially any symptoms of a possible concussion. Please contact the school's Sports Medicine Staff prior to scheduling any appointments for injuries sustained as a result of participation in athletics. I/We also understand that the Sports Medicine staff requires written documentation and clearance from any medical care received prior to returning to activities, even if it is not the result of participation in athletics. When the Sports Medicine staff determines that advanced medical care is required, the athlete must provide written clearance from an appropriate provider, prior to returning to participation. I/we will not condone participation in any activities against medical advice or until the athlete is cleared by an appropriate medical provider (as determined by the school's Sports Medicine staff).

Parent's Signature _____ Date _____
Student's Signature _____ Date _____

RICHLAND DISTRICT 2 SPORTS HEALTH FORM

Please print clearly. Please do not leave any blanks (mark "n/a" as appropriate).

Last Name _____ First Name _____ MI _____ Date of Birth ____/____/____

HEALTH INSURANCE INFORMATION

Does the above athlete receive Medicaid benefits? ____ Yes ____ No *(If yes, RSD2 insurance becomes primary coverage.)*

*Providing insurance information is **optional**, but may assist in more accurate claims processing in the event of an emergency when parents are not present. RSD2 does not file claims to private insurance companies, and it is ultimately the parents' responsibility to provide this information to all medical providers at the time of service.*

Insurance Provider _____ **Policy #** _____ **Group #** _____

Claims Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Policy Holder's Name _____ **Date of Birth** ____/____/____ **Relation to Athlete** _____

Policy Holder's Employer _____ **Referral required prior to specialist care?** ____ Yes ____ No

*Richland School District 2 carries athletic accident insurance on all its athletes, intended to be an "excess" policy designed to pay after the athlete's primary health insurance. In the event of injury, while participating as a part of a SCHSL sanctioned sports team representing RSD2, the athlete should seek the attention of their school's Sports Medicine staff as soon as possible. A staff member will fill out the top portion of the insurance claim form. The parent/guardian should complete the remainder of the form, follow the attached directions, and mail the completed form to the insurance company. **Medical care must be initiated within 60 days, and forms must be submitted directly to AIG Insurance Company by the PARENT within 90 days of the date of injury to be eligible for coverage. RSD2 or its schools cannot be held responsible for the financial or other costs associated with injuries sustained while participating in athletics.***

CONCUSSION INFORMATION

Further information regarding the recognition and management of concussion may be requested directly from the Head Athletic Trainer at any RSD2 high school. Parents of middle school students may request the assistance of any RSD2 high school athletic trainer in securing appropriate medical care if their child exhibits the signs or symptoms of concussion.

DISTRICT ATHLETIC TRAINER INFORMATION

The Richland Two Sports Medicine Team is dedicated to providing excellent medical services to athletes throughout the District. All parents (including parents of middle school athletes) should feel free to contact a High School Athletic Trainer should you have any health or injury related questions or concerns regarding your child's participation in athletics in Richland Two.

Athletic Trainers (ATs) are health care professionals who collaborate with physicians. The services provided by ATs comprise prevention, emergency care, clinical diagnosis, therapeutic intervention and rehabilitation of injuries and medical conditions. Students who want to become certified athletic trainers must earn a degree from an accredited athletic training curriculum. Accredited programs include formal instruction in areas such as injury/illness prevention, first aid and emergency care, assessment of injury/illness, human anatomy and physiology, therapeutic modalities, and nutrition. Classroom learning is enhanced through clinical education experiences. More than 70 percent of certified athletic trainers hold at least a master's degree. For more information about the education and qualifications of Athletic Trainers, visit www.nata.org.

High School	Athletic Trainer	Email	Phone
Blythewood	Steve Meisel	smeisel@richland2.org	803-691-4090 ext. 28932
Richland Northeast	Nicole Barton	nbarton@richland2.org	803-699-2800 ext. 79867
Ridge View	Mike Crook	jcrook@richland2.org	803-699-2999 ext. 69908
Spring Valley	Julie Sandy	jsandy@richland2.org	803-699-3500 ext. 69908
Westwood	Jason Nussbaum	jnussbaum@richland2.org	803-691-4049 ext. 36829



A Fact Sheet for **ATHLETES**

CONCUSSION FACTS

A concussion is a brain injury that affects how your brain works.

- A concussion is caused by a bump, blow, or jolt to the head or body.
- A concussion can happen even if you haven't been knocked out.
- If you think you have a concussion, you should not return to play on the day of the injury and not until a health care professional says you are OK to return to play.

CONCUSSION SIGNS AND SYMPTOMS

Concussion symptoms differ with each person and with each injury, and they may not be noticeable for hours or days. Common symptoms include:

- Headache
- Confusion
- Difficulty remembering or paying attention
- Balance problems or dizziness
- Feeling sluggish, hazy, foggy, or groggy
- Feeling irritable, more emotional, or "down"
- Nausea or vomiting
- Bothered by light or noise
- Double or blurry vision
- Slowed reaction time
- Sleep problems
- Loss of consciousness

During recovery, exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse.

WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

- **DON'T HIDE IT. REPORT IT.** Ignoring your symptoms and trying to "tough it out" often makes symptoms worse. Tell your coach, parent, and athletic trainer if you think you or one of your teammates may have a concussion. Don't let anyone pressure you into continuing to practice or play with a concussion.
- **GET CHECKED OUT.** Only a health care professional can tell if you have a concussion and when it's OK to return to play. Sports have injury timeouts and player substitutions so that you can get checked out and the team can perform at its best. The sooner you get checked out, the sooner you may be able to safely return to play.
- **TAKE CARE OF YOUR BRAIN.** A concussion can affect your ability to do schoolwork and other activities. Most athletes with a concussion get better and return to sports, but it is important to rest and give your brain time to heal. A repeat concussion that occurs while your brain is still healing can cause long-term problems that may change your life forever.

HOW CAN I HELP PREVENT A CONCUSSION?

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

- 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.

For more information, visit www.cdc.gov/Concussion.



A Fact Sheet for PARENTS

WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury. Concussions are caused by a bump or blow to the head. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

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 or weeks after the injury. If your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

WHAT ARE THE SIGNS AND SYMPTOMS OF A CONCUSSION?

Signs Observed by Parents or Guardians

If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs and symptoms of a concussion:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes

Symptoms Reported by Athlete

- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just “not feeling right” or “feeling down”

HOW CAN YOU HELP YOUR CHILD PREVENT A CONCUSSION OR OTHER SERIOUS BRAIN INJURY?

- Ensure that they follow their coach’s rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.
- Make sure they wear the right protective equipment for their activity. Protective equipment should fit properly and be well maintained.
- Wearing a helmet is a must to reduce the risk of a serious brain injury or skull fracture.
 - However, helmets are not designed to prevent concussions. There is no “concussion-proof” helmet. So, even with a helmet, it is important for kids and teens to avoid hits to the head.

WHAT SHOULD YOU DO IF YOU THINK YOUR CHILD HAS A CONCUSSION?

1. SEEK MEDICAL ATTENTION RIGHT AWAY.

A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to regular activities, including sports.

2. KEEP YOUR CHILD OUT OF PLAY.

Concussions take time to heal. Don’t let your child return to play the day of the injury and until a health care professional says it’s OK. Children who return to play too soon—while the brain is still healing—risk a greater chance of having a repeat concussion. Repeat or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.

3. TELL YOUR CHILD’S COACH ABOUT ANY PREVIOUS CONCUSSION.

Coaches should know if your child had a previous concussion. Your child’s coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

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

For more information, visit www.cdc.gov/Concussion.