

**INSTRUCTIONS**  
**SPORT PHYSICALS – 2010-11**

1. All athletes are required to complete the following:
  - Sports Physical completed by physician (must be within 365 days of the first day of practice – i.e. August 16 for fall football and tennis; August 20 for other fall sports); all physicals expire 365 days after they are performed. An updated Sports Physical **MUST** be on file in the Health Office for each athlete.
  - Health History Update (must be completed for EACH sporting season and be dated within 60 days of the start of each sport).
  - Consent to Random Drug Testing form as required by NJSIAA (required to be completed once per year);
  - Emergency Information Sheet (required to be completed once per year).
  - Consent for ImpACT Cognitive Testing (required to be completed once per year).
  - Card stock Advised Consent Form (must be completed for EACH season). This form is **NOT** available online and will be distributed at pre-season meeting or may be picked up from the Nurse's Office.
2. For your convenience, **ALL** required forms, with the exception of the Advised Consent Form (as noted above) must be downloaded from our website by going to [www.mtps.com](http://www.mtps.com), going to High School page, clicking on Athletics and clicking on Athletic Forms. All forms must be submitted together at one time, including the Advised Consent Form, which will be distributed at preseason meeting.
3. **IF YOUR LAST SPORT PHYSICAL IS LESS THAN 365 DAYS** from August 16 for football or tennis and August 20 for all other fall sports, (first day of practice) **AND** you have previously submitted a copy of that physical to the Health Office, you still **must** complete **ALL** paperwork with the exception of Part B: Physical Evaluation Form.
4. Sport physical forms must be filled out **completely** – if your physician does not fill out all information (Example: for vision 20/\_\_\_\_\_R 20/\_\_\_\_L) we must reject your physical form. Please make sure all spaces on the physical form are complete.
5. All completed paperwork must be handed in at one time -- **NO LATER THAN MONDAY, AUGUST 9**. **As noted above, all paperwork must be submitted at SAME time – including downloaded forms along with Advised Consent Form which will be distributed at preseason meeting.** Due to the large number of athletes, we are **UNABLE** to accept paperwork piecemeal. There will be no guarantee you will be eligible to participate if all paperwork is not handed in by the due date. Please drop off forms in the “Athletic Forms” box located on the counter in the High School main office.

**For Upperclassmen only: Academically you must have earned 27.5 credits or you must go to summer school and successfully complete the program to be eligible.**

6. If you do not have a physician or cannot get an appointment, the school physician (Dr. Summersgill) will provide physicals on July 8<sup>th</sup> or July 9<sup>th</sup>. You must arrive at the High School Health Office **PROMPTLY** at 8:00 a.m. on Thursday, July 8<sup>th</sup> or Friday, July 9<sup>th</sup> if you wish to be seen by Dr. Summersgill. Dr. Summersgill will also perform sports physicals periodically throughout the school year on the following dates: 9/30/10, 10/28/10, 11/18/10, 12/9/10, 2/10/11 and 2/24/11.

# New Jersey Department of Education ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

**Part A: HEALTH HISTORY QUESTIONNAIRE**-Completed by the parent and student and reviewed by examining provider  
**Part B: PHYSICAL EVALUATION FORM**-Completed by examining licensed provider with MD, DO, APN or PA

## Part A: HEALTH HISTORY QUESTIONNAIRE

Today's Date: \_\_\_\_\_ Date of Last Sports Physical: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Sex: M F (circle one) Age: \_\_\_\_ Grade: \_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ School: \_\_\_\_\_ District: \_\_\_\_\_  
 Sport(s): \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
 Provider Name (Medical Home): \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Name of parent/guardian: \_\_\_\_\_ Relationship to student: \_\_\_\_\_  
 Phone (work): \_\_\_\_\_ Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_  
 Additional emergency contact: \_\_\_\_\_ Relationship to student: \_\_\_\_\_  
 Phone (work): \_\_\_\_\_ Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_

**Directions:** Please answer the following questions about the student's medical history by **CIRCLING** the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

**1. Have you ever had, or do you currently have:**

- |  |                           |
|--|---------------------------|
| a. Restriction from sports for a health related problem?   | Y / N / Don't Know        |
| b. An injury or illness since your last exam?  | Y / N / Don't Know        |
| c. A chronic or ongoing illness (such as diabetes or asthma)?  | Y / N / Don't Know        |
| (1.) An inhaler or other prescription medicine to control asthma?  | Y / N / Don't Know        |
| d. Any prescribed or over the counter medications that you take on a regular basis?  | Y / N / Don't Know        |
| e. Surgery, hospitalization or any emergency room visit(s)?  | Y / N / Don't Know        |
| f. Any <b>allergies</b> to medications?  | <b>Y / N / Don't Know</b> |
| g. Any allergies to bee stings, pollen, latex or foods?  | Y / N / Don't Know        |
| (1.) If yes, check type of reaction:   |                           |
| <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Breathing or other anaphylactic reaction |                           |
| (2.) Take any medication/Epipen taken for allergy symptoms? (List below.)  | Y / N / Don't Know        |
| h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders?                         | Y / N / Don't Know        |
| i. A blood relative who died before age 50?  | Y / N / Don't Know        |

Explain all "yes" answers here (include relevant dates):

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**List all medications here:**

Medication Name	Dosage	Frequency

2. **Have you ever had, or do you currently have, any of the following *head-related* conditions:**

- |   |                    |
|---|--------------------|
| a. Concussion or head injury (including "bell rung" or a "ding")? | Y / N / Don't Know |
| b. Memory loss?   | Y / N / Don't Know |
| c. Knocked out?   | Y / N / Don't Know |
| c. A seizure?   | Y / N / Don't Know |
| d. Frequent or severe headaches (With or without exercise)?       | Y / N / Don't Know |
| e. Fuzzy or blurry vision   | Y / N / Don't Know |
| f. Sensitivity to light/noise                                     | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

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3. **Have you ever had, or do you currently have, any of the following *heart-related* conditions:**

- |  |                    |
|--|--------------------|
| a. Restriction from sports for heart problems?   | Y / N / Don't Know |
| b. Chest pain or discomfort?   | Y / N / Don't Know |
| c. Heart murmur?   | Y / N / Don't Know |
| d. High blood pressure?  | Y / N / Don't Know |
| e. Elevated cholesterol level?   | Y / N / Don't Know |
| f. Heart infection?  | Y / N / Don't Know |
| g. Dizziness or passing out during or after exercise without known cause?                        | Y / N / Don't Know |
| h. Has a provider ever ordered a heart test ( EKG, echocardiogram, stress test, Holter monitor)? | Y / N / Don't Know |
| i. Racing or skipped heartbeats?   | Y / N / Don't Know |
| j. Unexplained difficulty breathing or fatigue during exercise?                                  | Y / N / Don't Know |
| k. Any family member (blood relative):   |                    |
| (1.) Under age 50 with a heart condition?  | Y / N / Don't Know |
| (2.) With Marfan Syndrome?   | Y / N / Don't Know |
| (3.) Died of a heart problem before age 50? If yes, at what age? _____                           | Y / N / Don't Know |
| (4.) Died with no known reason?  | Y / N / Don't Know |
| (5.) Died while exercising? If yes, was it during or after? (Circle one.)                        | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

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4. **Have you ever had, or do you currently have, any of the following *eye, ear, nose, mouth or throat* conditions:**

- |   |                    |
|---|--------------------|
| a. Vision problems?   | Y / N / Don't Know |
| (1.) Wear contacts, eyeglasses or protective eye wear? (Circle which type.) | Y / N / Don't Know |
| b. Hearing loss or problems?  | Y / N / Don't Know |
| (1.) Wear hearing aides or implants?  | Y / N / Don't Know |
| c. Nasal fractures or frequent nose bleeds?                                 | Y / N / Don't Know |
| d. Wear braces, retainer or protective mouth gear?                          | Y / N / Don't Know |
| e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

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5. **Have you ever had, or do you currently have, any of the following *neuromuscular/orthopedic* conditions.**

- |   |                    |
|---|--------------------|
| a. Numbness, a "burner", "stinger" or pinched nerve?      | Y / N / Don't Know |
| b. A sprain?  | Y / N / Don't Know |
| c. A strain?  | Y / N / Don't Know |
| d. Swelling or pain in muscles, tendons, bones or joints? | Y / N / Don't Know |
| e. Dislocated joint(s)?                                   | Y / N / Don't Know |
| f. Upper or lower back pain?                              | Y / N / Don't Know |
| g. Fracture(s), stress fracture(s), or broken bone(s)?    | Y / N / Don't Know |
| h. Do you wear any protective braces or equipment?        | Y / N / Don't Know |

Explain all (yes) answers here (include relevant dates):

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6. Have you ever had or do you currently have any of the following *general or exercise related conditions*:

- a. Difficulty breathing?
  - (1.) During exercise? Y / N / Don't Know
  - (2.) After running one mile? Y / N / Don't Know
  - (3.) Coughing, wheezing or shortness of breath in weather changes? Y / N / Don't Know
  - (4.) Exercise-induced asthma? Y / N / Don't Know
    - i. Controlled with medication? (specify \_\_\_\_\_) Y / N / Don't Know
    - ii. Experience dizziness, passing out or fainting? Y / N / Don't Know
- b. Viral infections (e.g. mono, hepatitis, coxsackie virus)? Y / N / Don't Know
- c. Become tired more quickly than others? Y / N / Don't Know
- d. Any of the following skin conditions:
  - (1.) Cold sores/herpes, impetigo, MRSA, ringworm, warts? Y / N / Don't Know
  - (2.) Sun sensitivity? Y / N / Don't Know
- e. Weight gain/loss (of 10 pounds or more)? Y / N / Don't Know
  - (1.) Do you want to weigh more or less than you do now? Y / N / Don't Know
- f. Ever had feelings of depression? Y / N / Don't Know
- g. Heat-related problems (dehydration, dizziness, fatigue, headache)? Y / N / Don't Know
  - (1.) Heat exhaustion (cool, clammy, damp skin)? Y / N / Don't Know
  - (2.) Heat stroke (hot, red, dry skin)? Y / N / Don't Know
  - (3.) Muscle cramps? Y / N / Don't Know
- h. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

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7. **Females only:**

Age of onset of menstruation: \_\_\_\_\_ How many menstrual periods in the last twelve (12) months? \_\_\_\_\_

How many periods missed in the last twelve (12) months? \_\_\_\_\_

8. **Males only:**

Have you had any swelling or pain in your testicles or groin? Y / N / Don't Know

PARENT/GUARDIAN SIGNATURE

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

\_\_\_\_\_  
Signature, Parent/Guardian or Student Age 18

\_\_\_\_\_  
Date of Signature:

**THIS COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAM.**

# ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

## Part B: Physical Evaluation Form

(Completed by the examining licensed provider MD, DO, APN or PA)

### -STUDENT INFORMATION-

Student's Name: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
 Sex: M F (circle one) Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 School: \_\_\_\_\_ District: \_\_\_\_\_  
 Parent/Guardian's Full Name: \_\_\_\_\_

### - EXAMINING PHYSICIAN/PROVIDER CONTACT INFORMATION-

If conducted by school physician check here

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

### - FINDINGS OF PHYSICAL EVALUATION -

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_ bpm.  
 Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Y / N Contacts: Y / N Glasses: Y / N

INDICATORS	NORMAL?	ABNORMAL FINDINGS/COMMENTS
General Appearance	YES	
Head/Neck	YES	
Eyes/Sclera/Pupils	YES	
Ears	YES	
Gross Hearing	YES	
Nose/Mouth/Throat	YES	
Lymph Glands	YES	
Cardiovascular	YES	
Heart Rate	YES	
Rhythm	YES	
Murmur	ABSENT	
If murmur present		Standing makes it:   Louder           Softer           No Change
		Squatting makes it:   Louder           Softer           No Change
		Valsalva makes it:    Louder           Softer           No Change
Femoral Pulses	YES	
Lungs: Auscultation/Percussion	YES	
Chest Contour	YES	
Skin	YES	
Abdomen (liver, spleen, masses)	YES	
Assessment of physical maturation or Tanner Scale	YES	
Testicular Exam (Males Only)	YES	
Neck/Back/Spine:	YES	
Range of Motion	YES	
Scoliosis	ABSENT	
Upper Extremities: (ROM, Strength, Stability)	YES	
Lower Extremities: (ROM, Strength, Stability)	YES	
Neurological: Balance & Coordination	YES	
Hernia	ABSENT	
Evidence of Marfan Syndrome	ABSENT	

Most recent immunizations and dates administered:

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Medications currently prescribed, with dose and frequency:

Medication Name	Dosage	Frequency

Additional observations:

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General Diagnosis:

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General Recommendations:

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**THE HISTORY PREPARED BY THE PARENT/STUDENT MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE PHYSICAL EXAMINATION.**

**CLEARANCES: This section is completed by the examining healthcare provider.**

After examining the student and reviewing the medical history the student is:

- A. Cleared for participation in all sports without restrictions.
- B. Not cleared for participation in any sport until evaluation/treatment of:

\_\_\_\_\_

- C. Cleared for limited participation in the following types of sports only. Please see below for sport classifications. CHECK ALL THAT APPLY

\_\_\_ CONTACT/COLLISION  
\_\_\_ LIMITED CONTACT

\_\_\_ NON-CONTACT/STRENUOUS  
\_\_\_ NON-CONTACT/NON-STRENUOUS

Limitations due to: \_\_\_\_\_

**NOTES TO THE EXAMINING PROVIDER**

Conditions requiring clearance before sports participation include, but are not limited to the following:

Anaphylaxis; Atlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes mellitus; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly; Splenomegaly; Malignancy; Seizure Disorder; Marfan's Syndrome; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

**SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT**

Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-strenuous
Basketball	Baseball	Discus	Bowling
Diving	Cheerleading	Javelin	Golf
Field Hockey	Fencing	Shot put	
Football	High Jump	Rowing	
Ice Hockey	Pole vault	Running/Cross Country	
Lacrosse	Gymnastics	Strength Training	
Soccer	Skiing	Swimming	
Wrestling	Softball	Tennis	
	Volleyball	Track	

**Effects of physiologic maneuvers on heart sounds**

Standing      Increases murmur of HCM  
Decreases murmur of AS, MR  
MVP click occurs earlier in systole

Squatting      Increases murmur of AS, MR, AI  
Decreases murmur of MCH  
MVP click delayed

Valsalva      Increases murmur of HCM  
Decreases murmur of AS, MR  
MVP click occurs earlier in systole

**Physical Stigmata of Marfan's Syndrome**

Kyphosis  
High arched palate  
Pectus excavatum  
Arachnodactyly  
Arm span > height 1.05:1 or greater  
Mitral Valve Prolapse  
Aortic Insufficiency  
Myopia  
Lenticular dislocation

HCM: Hypertrophic Cardio Myopathy  
AS: Aortic Stenosis  
AI: Aortic Insufficiency  
MR: Mitral Regugitation  
MVP: Mitral Valve Prolapse

HISTORY REVIEWED AND STUDENT EXAMINED BY: Physician's/Provider's Stamp:

- Primary Care Provider
- School Physician Provider
- License Type:
  - MD/DO
  - APN
  - PA

PHYSICIAN'S/PROVIDER'S SIGNATURE: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Exam: \_\_\_\_\_

**RESERVED FOR SCHOOL DISTRICT USE**

**NOTE:** *N.J.A.C. 6A:16-2.2* requires the school physician to provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in athletics based on this physical evaluation. This evaluation and the notification letter become part of the student's school health record.

History and Physical Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

Title of Reviewer (please check one):  School Nurse  School Physician

Medical Eligibility Notification Sent to Parent/Guardian by School Physician \_\_\_\_\_  
Date

Letter of notification is attached.

OR

Parent notification indicates that:

- Participation Approved without limitations.
- Participation Approved with limitations pending evaluation.
- Participation NOT Approved

Reason(s) for Disapproval: \_\_\_\_\_

\_\_\_\_\_

**2010 - 2011 SCHOOL YEAR**

**NJSIAA STEROID TESTING POLICY**

**CONSENT TO RANDOM TESTING**

In Executive Order 72, issued December 20, 2005, Governor Richard Codey directed the New Jersey Department of Education to work in conjunction with the New Jersey State Interscholastic Athletic association (NJSIAA) to develop and implement a program of random testing for steroids, of teams and individuals qualifying for championship games.

Beginning in the Fall, 2006 sports season, any student-athlete who possesses, distributes, ingests or otherwise uses any of the banned substances on the attached page, without written prescription by a fully-licensed physician, as recognized by the American Medical Association, to treat a medical condition, violates the NJSIAA's sportsmanship rule, and is subject to NJSIAA penalties, including ineligibility from competition. The NJSIAA will test certain randomly selected individuals and teams that qualify for a state championship tournament or state championship competition for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents, and his or her school. No student may participate in NJSIAA competition unless the student and the student's parent/guardian consent to random testing.

By signing below, we consent to random testing in accordance with the NJSIAA steroid testing policy. We understand that if the student or the student's team qualifies for a state championship tournament or state championship competition, the student may be subject to testing for banned substances.

\_\_\_\_\_  
Signature of student-athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

**MOORESTOWN HIGH SCHOOL  
EMERGENCY INFORMATION SHEET**

Athlete's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Person to contact in case of emergency other than parent or guardian:**

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Insurance Information:**

Name of Insured: \_\_\_\_\_

Employer of Insured: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy/Group #: \_\_\_\_\_

**Medical History:**

Chronic Illnesses (Diabetes, Asthma, etc.): \_\_\_\_\_

Allergic to any Medications: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital of Choice: \_\_\_\_\_

In the event of an emergency that may arise from my child's participation in school athletics, I hereby authorize the certified athletic trainer or coaching staff of Moorestown High School to consent to any medical treatment, diagnosis, and/or hospital care by a licensed physician.

**Date:** \_\_\_\_\_ **Parent/Guardian Signature:** \_\_\_\_\_

**Moorestown High School  
SCHOOL YEAR 2010-11**

**CONSENT FOR COGNITIVE TESTING and RELEASE OF INFORMATION**

I give my permission for (name of child) \_\_\_\_\_ (child's date of birth) \_\_\_\_\_ to undergo a Baseline ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) and a Post-Concussion ImPACT test, as necessary, administered at Moorestown High School. I understand that my child may need to be tested more than once, depending upon the results of the test, as compared to my child's baseline test, which is on file at MHS. I understand there is no charge for testing.

Moorestown High School may release the ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) results to my child's primary care physician, neurologist or other treating physician, as indicated below.

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

Name of parent or guardian: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian Preferred Contact Number: \_\_\_\_\_

**PLEASE PRINT THE FOLLOWING INFORMATION:**

Name of doctor: \_\_\_\_\_

Name of practice or group: \_\_\_\_\_

Phone number: \_\_\_\_\_

**CONCUSSION EDUCATION POLICY**

It is the policy of the New Jersey State Interscholastic Athletic Association (NJSIAA) that all participating student-athletes and their parents/guardians are informed about risks associated with the student-athlete continuing to play after sustaining a concussion. By signing below, you are acknowledging that both student-athlete and his/her parents/guardians have reviewed the NJSIAA Concussion Identification, Management and Return-to-Play Policy which can be found in the Moorestown High School Student Handbook and on our website under the Athletics tab.

\_\_\_\_\_  
Signature of student-athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

# **CONCUSSION IDENTIFICATION, MANAGEMENT AND RETURN-TO-PLAY**

## **NJSIAA Policy Statement**

Developed by the Medical Advisory Board

April, 2010

According to The Centers for Disease Control and Prevention, at least 3 million sports and recreation related concussions occur in the United State each year. Concussions are a serious and growing public health concern, especially for students participating in contact sports. The competitive athletic culture of playing through pain or “toughing it out” puts student-athletes at serious risk of brain injury, disability, and death. **Allowing a student-athlete to return-to-play before recovering from a concussion increases the chance of a more serious brain injury that can result in severe disability and/or death.** Currently, many student-athletes, school personnel including coaches, parents/guardians, and others involved in interscholastic athletics lack awareness about prevention, identification, and treatment of concussions as well as when it is most appropriate for the student-athlete to return-to-play.

The effects of concussion while not all preventable can be mitigated by prompt recognition and appropriate response. Therefore, the New Jersey State Interscholastic Athletic Association concludes that a viable public education program focused on concussion education, prevention, and a uniform return-to-play policy is in the best interest of student-athletes throughout the State of New Jersey.

A concussion is a type of traumatic brain injury (TBI) caused by a direct or indirect blow to the head. The injury can range from mild-to-severe, and can disrupt the way the brain normally functions. A student-athlete does not need to lose consciousness to sustain a concussion. You might notice some of the symptoms right away other symptoms can show up within hours, days or weeks after the injury.

### **NJSIAA POLICY STATEMENT:**

It is our recommendation that NJSIAA member high schools in conjunction with the NJSIAA develop a policy related to concussions including forms and guidelines in order to educate student-athletes, school personnel, and parents/guardians about concussion. These forms shall include risks associated with the student-athlete continuing to play after sustaining a concussion.

Parents/guardians of a student-athlete, who participates in interscholastic athletics, shall receive on an annual basis, per each year the student-athlete participates, a concussion informational sheet. The student-athlete and their parents/guardians shall sign one copy of the informational sheet along with all pre-participation examination forms, acknowledging the receipt of this information. These forms are to be given to the proper authorities in the school district prior to the student-athlete initiating involvement in athletics. Informational sheets and pre-participation examination forms shall be forwarded to the office of the Principal or their designate for the district. Failure to comply with the provision of this shall preclude the student-athlete from participating in athletics related to the desired sport.

The NJSIAA recognizes that a majority of member schools employ the services of an athletic trainer. As health care providers who work under the supervision of a licensed physician, athletic trainers serve as an extension of the physician, and play key role in a concussion education and management program. Schools that employ athletic trainers should ensure they play a central role in the school's concussion education and management program.

#### **ANNUAL TRAINING RELATED TO CONCUSSION:**

NJSIAA member high schools shall ensure that student-athletes, coaches, athletic trainers, and physicians employed by the school district and show proof of satisfactory completion of that training. Officials should receive annual training from their chapters. Concussion training will be applicable towards certified continuing education requirements.

#### **RETURN-TO-PLAY GUIDELINES:**

NJSIAA member high schools that partake in interscholastic athletics shall develop a written plan of policy to address incidents of suspected or actual concussion among participants that are involved in the district programs. A student-athlete who is suspected of sustaining or who has sustained a concussion and/or has become unconscious during an athletic event shall not return-to-play until (s)he meets all of the following criteria:

1. Immediate removal from play and no return-to-play that day.
2. Medical evaluation to determine the presence/absence of concussion.
3. It is recommended that the student-athlete diagnosed with a concussion complete a symptom-free week initiated on the first asymptomatic day before initiating a graduated return-to-play exercise protocol. The student-athlete must be monitored during this time period for any reoccurrence of concussion symptoms.

4. If the student-athlete exhibits a re-emergence of any post-concussion signs or symptoms once they return-to-play, they will be removed from exertional maneuvers and return to his/her primary care physician or the team doctor for reevaluation.
5. If concussion symptoms reoccur during the graduated return-to-play exercise protocol, the student-athlete will return to the previous level of activity that caused no symptoms and then advance as tolerated.
6. Utilization of available tools such as symptom checklists, baseline and balance testing are suggested.

### **POSSIBLE SIGNS AND SYMPTOMS OF CONCUSSION:**

Signs observed (a member of the coaching staff, athletic trainer, and/or physician) include but are not limited to:

1. Appears dazed, stunned, or disoriented.
2. Forgets plays or demonstrates short-term memory difficulties (e.g. is unsure of the game, score, or opponent).
3. Exhibits difficulties with balance or coordination.
4. Answers questions slowly or inaccurately.
5. Loses consciousness.
6. Demonstrates behavior or personality changes.
7. Is unable to recall events prior to or after the hit.

Symptoms reported by the student-athlete to a member of the coaching staff, athletic trainer, and/or physician include but are not limited to:

1. Headache.
2. Nausea/vomiting.
3. Balance problems or dizziness.
4. Double vision or changes in vision.
5. Sensitivity to light or sound/noise.
6. Feeling of sluggishness or fogginess.
7. Difficulty with concentration, short-term memory, and/or confusion.
8. Irritability or agitation.
9. Depression or anxiety.
10. Sleep disturbance.

### **GRADUATED RETURN-TO-PLAY EXERCISE PROTOCOL:**

Step 1: No activity, complete physical and cognitive rest. The objective of this step is recovery.

- Step 2: Light aerobic exercise, which includes walking, swimming or stationary cycling, keeping the intensity < 70% maximum percentage heart rate; no resistance training. The objective of this step is increased heart rate.
- Step 3: Sport-specific exercise including skating, and/or running drills; no head impact activities. The objective of this step is to add movement.
- Step 4: Non-contact training drills involving progression to more complex training drills (e.g. passing drills). The student-athlete may initiate progressive resistance training.
- Step 5: Following medical clearance, participation in normal training activities. The objective of this step is to restore confidence and assess functional skills by the coaching staff.
- Step 6: Return to play involving normal exertional or game activity.

**Reference:** Consensus Statement on Concussion in Sports, 3<sup>rd</sup> International Conference on Concussion in Sport held in Zurich, November 2008. *Clinical Journal of Sport Medicine*, Volume 19, No. 3 May 2009, pp. 185-200.

**FINAL STATEMENTS:**

The NJSIAA recognizes that although outside of our purview, student-athletes must also return to the classroom post-concussion. NJSIAA member high schools shall recognize that the aforementioned signs and symptoms of concussion also impact the student-athlete in their academic pursuits which can cause a deleterious effect on their ability to function in the classroom, learn new material, complete homework and study for tests. Parents/guardians should also be aware that driving may be impaired during the post-concussion period.

This NJSIAA policy is a dynamic document which will be altered or amended as new clinical research becomes available.