2021-2022
DIAA ATHLETIC PHYSICAL AND CONSENT FORMS

Upon publication of this packet, these forms **MUST** be utilized when completing required DIAA forms for athletic participation.. Each year, the DIAA will utilize this cover letter to update providers on any important changes and important dates.

The DIAA Sports Medicine Advisory Committee recommends that the required forms be completed by the student athlete's primary care provider (medical home) to ensure continuity of medical care. These forms must be completed **after April 1st each year based on a physical performed by the signing physician within one year of the date of signature.**

Key Changes:

- Please refer to updated COVID information sheets and regulations for latest health and safety information.
- On the history form(page 3), all questions should be answered based on complete medical history (not just in the last year).
- On the physical form (page 4), a section for date of clearance has been added next to the "signature of health care professional". The date the forms are filled out does not have to be the same day that the physical was performed. See above for timing of physical.

Need parent/guardian signature
Need student/athlete signature
Need medical professional signature

Delaware Interscholastic Athletic Association
Pre-Participation Physical Evaluation/Consent Form

The DIAA pre-participation physical evaluation and consent form consists of seven pages. Pages two, three and five require a parent's signature while pages six and seven are references for the parent and student athlete to keep. Page four requires the exam date and physician's signature and page five requires the clearance to participate date and physician's signature. **The student must be cleared to participate on or after April 1 based on a physical examination conducted within 12 months of the signature. The clearance is valid through June 30 of the following school year unless a re-examination is required.**

Name of Athlete: _____ School: _____
Grade: _____ Age: _____ Gender: _____ Date of Birth: _____ Phone: _____
Parent/Guardian Name: (Please Print): _____

For the physicals of 9th graders or new school enterers, please check here indicating immunization form attached: ☐

PARENT/GUARDIAN/STUDENT CONSENTS

_____has my permission to participate in all interscholastic sports **NOT** checked below
(Name of Athlete)

NOTE- ***If you check any sport*** below, the athlete will ***NOT*** be permitted to participate in that sport.

____Baseball	____Basketball (G)(B)	____Cross Country (G)(B)	____Field Hockey	____Football
____Golf	____Lacrosse (G)(B)	____Soccer (G)(B)	____Softball	____Swimming (G)(B)
____Tennis (G) (B)	____Track (G) (B)	____Volleyball	____Wrestling	____Cheerleading
____Unified Football	____Unified Basketball	____Unified Track	____Other_____	____Other_____

1. My permission extends to all interscholastic activities whether conducted on or off school premises. I have read and discussed the **Parent/Player Concussion Information Document; Sudden Cardiac Arrest Awareness Sheet** and I will retain those pages for my reference. I have also discussed with him/her and we understand that physical injury, including paralysis, coma or death *and exposure to COVID-19* can occur as a result of participation in interscholastic athletics. I waive any claim for injury, *illness,* or damage incurred by said participant while participating in the activities NOT checked above.

Parent Signature:_____ **Date:**_____

Student Signature:_____ **Date:**_____

2. To enable DIAA and its full and associate member schools to determine whether herein named student is eligible to participate in interscholastic athletics, I hereby consent to the release of any and all portions of school record files, beginning with the sixth grade, of the herein named student, including but not limited to, birth and age records, name and residence of student's parent(s), guardian(s) or Relative Care Giver, residence of student, health records, academic work completed, grades received and attendance records.

Parent Signature:_____ **Date:**_____

3. I further consent to DIAA and it's full and associate member schools use of the herein named student's name, likeness, and athletically related information in reports of interscholastic practices, scrimmages or contests, promotional literature of the association, and other materials and releases related to interscholastic athletics.

Parent Signature: _____ **Date:**_____

4. By this signature, I hereby consent to allow the physician(s) and other health care provider(s) selected by myself or the schools to perform a pre-participation examination on my child and to provide treatment for any injury received while participating in or training for athletics for his/her school. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation, with coaches, medical staff, Delaware Interscholastic Athletic Association, and other school personnel as deemed necessary. Such information may be used for injury surveillance purposes.

Parent Signature: _____ **Date:**_____

5. **By this signature, I agree to notify the physician and school of any health changes during the school year that could impact participation in interscholastic athletics**.

Parent Signature: _____ **Date:** _____

HISTORY FORM *Form completed annually along with a Consent & Medical Card. Athlete and parent should fill out form prior to visit.

Name _____ Age: _____ Date of Birth: _____ Grade: _____

Sex assigned at birth (F,M, or Intersex) _____ How do you identify your gender? (F, M, Other)____ School_____ Sport(s)_____

List past and current medical conditions:			Have you ever had surgery? If yes list all past surgical procedures:	
List all current prescriptions, otc medicines, and supplements (herbal & nutritional):			List all of your allergies (medicines, pollens, food, stinging insects etc):	
Over the past 2 weeks, how often have you been bothered by any of the following (circle)	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Mental Health: A sum of >= 3 for questions 1+2, or 3+4, is considered positive				

. * See repeat responders versus first responders

GENERAL QUESTIONS	Yes	No
1. Doyouhaveany concerns you wouldlike todiscuss with your provider?		
2. Hasaprovidereverdeniedor restricted your participationin sports forany reason?		
3. Doyouhaveany medical issuesor recentillness?		
HEART HEALTH QUESTIONS ABOUT YOU:	Yes	No
4.Haveyouever passed outor nearly passed out duringor afterexercise?		
5. Haveyou everhaddiscomfort, pain, tightness, or pressure in your chest during exercise?		
6. Doesyourheart everrace, flutter in your chest,*or*skip beats (irregularbeats) duringexercise?		
7. Hasa doctor told you thatyouhaveanyheart issues?		
8. Hasadoctor ever requesteda testfor yourheart?For example, electrocardiogram (EKG)or echocardiogram?		
9. Doyougetlightheadedor feel shorterofbreath more thanyour friends duringexercise ?		
10. Have youeverhada seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
11.Has any family member or relative died of heart problems or had an unexpectedor unexplainedsuddendeath beforeage35years (includingdrowningorunexplainedcar crash)?		
12.Does anyone in your family have a genetic heart problem suchas hypertrophiccardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy(ARVC), long QT syndrome (LQTS),. short QTsyndrome (SQTS), Brugada syndrome, or catecholaminergicpolymorphicventricular hycardia(CPVT)?		
13. Has anyoneinyour family hadapacemaker ,or implanteddefibrillator before age35?		
BONE AND JOINT QUESTIONS	Yes	No
14. Since youwere last cleared toplay sports,have you hadanewinjurytoabone, muscle,ligament ortendon?		
MEDICAL QUESTIONS		
15. Have you been diagnosed with COVID-19?		
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or, testicle pain or a painful bulge or hernia in the groin area?		
19. Doyouhaveany recurring skin rashes or rashes thatcome andgo,including herpes or methicillin-resistant*Staphlocccus aureus*(MRSA)?		

	Yes	No
20. Haveyou hadaconcussion orhead injury that causedconfusion,aprolonged headache,or memoryproblem?		
21. Haveyou everhadnumbness, tingling,weaknessin yourarms orleg orbeen unable to moveyour arms or legsafter beinghit orfalling?		
22 .Haveyoueverbecomeillduring exercisingin theheat?		
23. Doyouor someone inyour family havesicklecell traitor disease?		
24. Have you ever hadordo youhaveproblems with youreyesor vision?		
25.Do you worry muchabout your weight?		
26.Are you tryingorhas anyonerecommendedyou gainorlose weight?		
27.Are youona special dietor do youavoidcertain typesoffoods orfoodgroups?		
28.Have youeverhadaneatingdisorder?		
FEMALES ONLY		
29. Have you ever hada menstrual period?		
30. Howold were youwhenyouhad your first menstrual period? _____		
31. Whenwasyour mostrecent menstrual period?		
32. How manyperiods have you*had*in the last12 months?_____		

Answer "Yes" if ever occurred. Explain "yes"answershere:

SCHOOL QUALIFIED HEALTHCARE PROFESSIONAL: (RN/AT)
If "yes is answered to any of the above, or "3+ for mental health questions, since the athlete was last cleared for athletic participation, a referral and clearance by the athlete's primary care provider is required.

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

Signature of Athlete:_____ Date:_____ Signature Parent/Guardian:_____ Date:_____

Rev 4/1/21

PHYSICAL EXAMINATION FORM*

Name_____Date of Birth_____

PHYSICIAN REMINDERS

1. Consider additionalquestionsonmoresensitiveissues

- Do youfeel stressed out or under alotof pressure?
- Do you everfeelsad, hopeless,depressed, oranxious?
- Do youfeel safe at your home or residence?
- Haveyouevertriedcigarettes,chewing tobacco,snuff, ordip?
- During the past 30 days,did you use chewingtobacco,snuff, or dip?
- Do you drinkalcohol or use any other drugs?
- Haveyou ever taken anabolicsteroids or used any other performance-enhancing supplement?
- Haveyou ever taken anysupplementsto helpyou gain or lose weightor improveyour performance?
- Do youwear a seatbell, use ahelmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (Q4-Q13 of HistoryForm)

EXAMINATION		
Height Weight		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ❑ Y ❑ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart' • Murmurs (auscultation standing, supine, +/- Valsalva)		
Lungs		
Abdomen		
Skin Herpes simplex virus(HSV), lesions suggestive of methicillin-resistant Staphlococcus aureus(MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

'Consider ECG, echocardiogram, echocardiography, referral to cardiologist for abnormal cardiac history or examination findings, or a combination of these.

HEALTHCARE PROFESSIONAL: THIS FORM[[3] MUST BE USED IN CONJUNCTION WITH MEDICAL HISTORY FORM [3] AND MEDICAL CARD [5]. THIS FORM AND MEDICAL CARD MUST BE SIGNED BY MD/DO/NP/PA

Comments:

Name of HealthCare Professional (MD/DO,NP,PA) print or type:_____ Date of Exam:_____

Address:_____Phone:_____

Signature of HealthCare Professional:_____Date of Clearance_____

Please sign pages four and five of the pre-participation packet

SCHOOL ATHLETE MEDICAL CARD *

(Parent/Guardian: Please complete Sections 1, 2 & 3. Please print.)

Section 1: Contact /Personal Information

Name: _____ Sport(s): _____

Age: _____ Birthdate: _____ School: _____ Grade: _____

Guardian Name: _____

Address: _____

Phone: (H) _____ (W): _____ (C): _____ (P) _____

Other Authorized Person To Contact In Case Of Emergency:

Name: _____ Phone(s): _____

Name: _____ Phone(s): _____

Preference Of Physician (And Permission To Contact If Needed): _____

Name: _____ Phone: _____

Hospital Preference: _____ Insurance: _____

Policy #: _____ Group: _____ Phone: _____

Section 2: Medical Information *(please complete in full using N/A if needed)*

Medical Illnesses: _____

Last Tetanus (Mo/Yr): _____ Allergies: _____ Braces/Splints: _____

Medications: _____

(Any medication(s) that may need to be taken during competition require a physician's note.)

Previous Head/Neck/Back Injury: _____

Heat Disorder, Or Sickle Cell Trait: _____

Previous Significant Injuries: _____

Any Other Important Medical Information: _____

Section 3: Consent for Athletic Conditioning, Training and Health Care Procedures

I hereby give consent for my child to participate in the school's athletic conditioning and training program, and to receive any necessary healthcare treatment including first aid, diagnostic procedures, and medical treatment, that may be provided by the treating physicians, nurses, athletic trainers, or other healthcare providers employed directly or through a contract by the school, or the opposing team's school. The healthcare providers have my permission to release my child's medical information to other healthcare practitioners and school officials. In the event I cannot be reached in an emergency I give permission for my child to be transported to receive necessary treatment. I understand that Delaware Interscholastic Athletic Association or its associates may request information regarding the athlete's health status, and I hereby give my permission for the release of this information as long as the information does not personally identify my child.

Parent/Guardian Signature: _____ **Date**: _____

Athlete's Signature: _____ **Date**: _____

Section 4: Clearance for Participation

____ Not Cleared _____ Cleared without restrictions _____ Cleared with the following restrictions: _____

_____

Health Care Provider's Signature: _____ MD/DO, PA, NP Date: _____

If this form is being completed as part of the supplemental form, then a physician signature is not needed until a new physical is performed.

***For School Office Use Only**: This card is valid from April 1, 20 _____ through June 30, 20 _____*

Note: If any changes occur, a new card should be completed by the parent/guardian. The original card should be kept on file in the school nurse, athletic director's or athletic trainer's office. A copy should be kept in the sports' athletic kit. This card contains personal medical information and should be treated as confidential by the school, its employees, agents, and contractors.

***Name of School**: _____ **Name of School QHP:** _____*

Rev 4/1/21

Delaware Interscholastic Athletic Association
Parent/ Player Concussion Information Document

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:			**Signs observed by teammates, parents and coaches may include:**	
Headaches	Pressure in head	Nausea or vomiting	Appears dazed	Vacant facial expression
Neck pain	Balance problems	Dizziness	Confused about assignment	Forgets plays
Disturbed vision	Light/noise sensitivity	Sluggish	Unsure of game/score etc	Clumsy
Feeling foggy	Drowsiness	Changes in sleep	Responds slowly	Personality changes
Amnesia	"Don't feel right"	Low energy	Seizures	Behavior changes
Sadness	Nervousness	Irritability	Loss of consciousness	Uncoordinated
Confusion	Repeating questions	Concentration problems	Can't recall events before or after hit	

What can happen if my child keeps on playing with a concussion or returns to soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one (second impact syndrome). This can lead to prolonged recovery, or even to severe brain swelling with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often under report symptoms of injuries, and concussions are no different. As a result, education of administrators, coaches, parents and students is the key for the student-athlete's safety.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. You should also inform your child's coach if you think that your child may have a concussion Remember it is better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information from the CDC on concussions you can go to:
http://www.cdc.gov/headsup/youthsports/index.html
For a current update of DIAA policies and procedures on concussions you can go to:
https://www.doe.k12.de.us/Page/3298
For a free online training video on concussions you can go to :
https://nfhslearn.com/courses?searchText=Concussion

All parents and players must sign the signature portion of the PPE indicating they have read and understand the above.

Adapted from the KHSAA, CDC and 3rd International Conference on Concussion in Sport, 4/2011

SUDDEN CARDIAC ARREST AWARENESS SHEET

What is Sudden Cardiac Arrest?

- An electrical malfunction (short-circuit) causes the bottom chambers of the heart (ventricles) to beat dangerously fast (ventricular tachycardia or fibrillation) and disrupts the pumping ability of the heart.
- Occurs suddenly and often without warning.
- The heart cannot pump blood to the brain, lungs and other organs of the body.
- The person loses consciousness (passes out) and has no pulse.
- Death occurs within minutes if not treated.

What causes Sudden Cardiac Arrest?

- Conditions present at birth (inherited and non-inherited heart abnormalities)
- A blow to the chest (Commotio Cordis)
- An infection/inflammation of the heart, usually caused by a virus. (Myocarditis)
- Recreational/Performance-Enhancing drug use.
- Other cardiac & medical conditions/Unknown causes. (Obesity/Idiopathic)

What are the symptoms/warning signs of Sudden Cardiac Arrest?

- Fainting/blackouts (especially during exercise)
- Dizziness
- Unusual fatigue/weakness
- Chest pain
- Shortness of breath
- Nausea/vomiting
- Palpitations (heart is beating unusually fast or skipping beats)
- Family history of sudden cardiac arrest at age < 50

ANY of these symptoms/warning signs may necessitate further evaluation from your physician before returning to practice or a game.

What are ways to screen for Sudden Cardiac Arrest?

- The American Heart Association recommends a pre-participation history and physical including 12 important cardiac elements.
- **The DIAA *Pre-Participation Physical Evaluation – Medical History* form includes ALL 12 of these important cardiac elements and is mandatory annually. Please answer the heart history questions on the student health history section of the DIAA PPE carefully.**
- Additional screening using an electrocardiogram and/or an echocardiogram is readily available to all athletes, but is not mandatory.

Where can one find additional information?

- Contact your primary care physician
- American Heart Association (www.heart.org)
- August Heart (www.augustheart.org)
- Championship Hearts Foundation (www.champhearts.org)
- Cody Stephens Foundation (www.codystephensfoundation.org/)
- Parent Heart Watch (www.parentheartwatch.com)
- NFHS Learn Center – Sudden Cardiac Arrest Video (www.nfhslearn.com)

All parents and players must sign the signature portion of the PPE indicating they have read and understand the above.