Ralph Chandler Middle School

Athletics – Participation Packet

ALL Forms MUST be filled out completely and turned into the Athletic Director “prior” to Conditioning and Tryout opportunities here at RCMS.

- Pre-participation Physical Form
- Parents’ Permission & Acknowledgement Form.
- RCMS Behavior & Academics Contract.
- GHS/Steadman Hawkins Consent Authorization.
- GCS - Risk Acknowledgement Form.
- Athlete/Parent Concussion Statement
- Concussion Policy (No signature required).
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.

<table>
<thead>
<tr>
<th>GENERAL QUESTIONS</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has a doctor ever denied or restricted your participation in sports for any reason?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you have any ongoing medical conditions? If so, please identify below: □ Asthma □ Anemia □ Diabetes □ Infections □ Other: ___________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Have you ever spent the night in the hospital?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have you ever had surgery?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEART HEALTH QUESTIONS ABOUT YOU</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Have you ever passed out or nearly passed out DURING or AFTER exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Does your heart ever race or skip beats (irregular beats) during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: □ High blood pressure □ A heart murmur □ High cholesterol □ A heart infection □ Kawasaki disease □ Other: ___________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Has a doctor ever ordered a test for your heart? (For example, ECC/EGK, echocardiogram)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Do you get lightheaded or feel more short of breath than expected during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Have you ever had an unexplained seizure?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Do you get more tired or short of breath more quickly than your friends during exercise?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEART HEALTH QUESTIONS ABOUT YOUR FAMILY</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BONE AND JOINT QUESTIONS</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Have you ever had any broken or fractured bones or dislocated joints?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Have you ever had a stress fracture?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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 dwarfish)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Do you regularly use a brace, orthotics, or other assistive device?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Do you have a bone, muscle, or joint injury that bothers you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Do any of your joints become painful, swollen, feel warm, or look red?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Do you have any history of juvenile arthritis or connective tissue disease?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 ___________________________


9-16410
# Preparticipation Physical Evaluation

**PHYSICAL EXAMINATION FORM**

Name ___________________________ Date of birth _______________________

**PHYSICIAN REMINDERS**

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

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

---

## EXAMINATION

<table>
<thead>
<tr>
<th>BP</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ ( / )</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEDICAL**

**NORMAL** | **ABNORMAL FINDINGS**

<table>
<thead>
<tr>
<th>Appearance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morbid obesity (high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hypertrophy, myopia, MVP, aortic insufficiency)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eyes/ears/noes/throat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pupils equal</td>
</tr>
<tr>
<td>Hearing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lymph nodes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Heart</th>
</tr>
</thead>
<tbody>
<tr>
<td>Murmurs (auscultation standing, supine, +/− Valvular)</td>
</tr>
<tr>
<td>Location of point of maximal impulse (PM)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pulses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simultaneous femoral and radial pulses</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lungs</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Abdomen</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Genitourinary (males only)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSIs lesions suggestive of MRSA, tinea corporis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neurologic^3</th>
</tr>
</thead>
</table>

**MUSCULOSKELETAL**

<table>
<thead>
<tr>
<th>Neck</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Back</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Shoulder/arm</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Elbow/forearm</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Wrist/hand/tingers</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hip/Thigh</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Knee</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Leg/ankle</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Foot/toes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Functional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duck-walk, single leg hop</td>
</tr>
</tbody>
</table>

---

☐ 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. If conditions arise after the athlete had 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 ___________________________

---

Parent’s Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

Name (please print) __________________________

As a parent or legal guardian of the above named student-athlete, I give permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

Signature of Athlete __________________________ Date ______

Signature of Parent/Guardian ______________________ Date ______
At all times, Ralph Chandler student athletes are expected to represent themselves and RCMS well. This means good sportsmanship, good behavior, good language, and good effort.

**Academics**
RCMS Student Athletes are expected to maintain the highest academic standards.

- Participation in athletics is based on academic success.
- Grades will be reviewed for all students requesting to try out for any sport. Any current failing grade or failing grade from the previous semester may disqualify the student from the sport.
- Grades will be reviewed during the season, at the semester grading; any failing grade may have an impact on student’s eligibility. Any grade less than a 70; student can practice but can not play in season/playoff games.

**Behavior**
- The expectation is that all athletes are Student Athletes. Academic success and good behavior is expected at all times; participation in athletics is a privilege. Any behavior that results in an administrative referral may have an impact on student’s eligibility to play sports.
- If a student receives a behavior referral, the administration may consult the AD and/or coach.
- Coaches reserve the right to consult Athletic Director and Administration if there is a behavior issue.

**Try Outs and Practice**
- All try outs and practices are CLOSED, no parents or guardians allowed. Only coaches and Administrators are permitted. If parent or guardian refuses to leave, student will be sent home.
- No profanity by athletes directed at any player, coach, official, or parent is permitted for any reason. Any use of profanity, student may be ejected, and dismissal from team could result.
- Appropriate dress/attire is mandatory at all times. No bare chests or clothing that is inappropriate. Any athlete in inappropriate dress will be required to change or leave the facility.
- Protective gear must be worn at all times. If student fails to wear protective gear required, they may be sent home and not permitted to return until properly outfitted.
- All students are required to follow all rules and procedures as directed by coach.
- Coaches will provide athletes with a rubric at the start of try outs, so athletes understand what is expected of them.

**Game Day**
- All athletes are required to dress in appropriate uniform as directed by coach.
- No profanity by athletes directed at any player, coach, official, or parent is permitted for any reason. Any use of profanity, student may be ejected from game and immediate dismissal from team could result.
- All athletes are required to be on time.

**Parents**
- Parents/guardians are not permitted to attend or interfere with any part of practice or games at any time. ALL conditioning and practices are closed to the public.
- Parents are encouraged to model good sportsmanship regarding RCMS’s athletes and the athletes on the opposing team. “Sports Rage” is unacceptable.
- Parents are not permitted to consult or coach any player during games. Any parent interfering with the game may be asked to leave the facility.
- Any profanity by a parent directed at a player, coach, or official will not be permitted. If this occurs, parent may be asked to leave the facility.

I have read the above rules and expectations and commit to follow them.

Student: ______________________ Parent: ______________________
STEADMAN HAWKINS SPORTS MEDICINE SERVICES
CONSENT AND AUTHORIZATION

I, ____________________________, parent/legal guardian of ________________________________,
a student/participant at ________________________________ (the “School/Event”) authorize Greenville
Health System (“GHS”) staff to provide my child any healthcare services offered by Steadman Hawkins
Sports Medicine (“SHSM”) and to make appropriate referrals for my child to receive any additional
health services that my child’s condition may indicate. To protect and improve the health of athletes,
GHS will provide athletic trainers to provide on-site treatment and consultation to student/participants.
These services will be overseen by a physician serving as Medical Director for SHSM.

In addition, in the event my child needs urgent or emergency treatment off-site, I authorize staff of
SHSM to arrange for such care, including appropriate transportation. I understand that SHSM staff
will contact me as soon as possible in the event my child has an urgent or emergency condition. I
agree to complete all health history, family history, and other informational requests necessary for
my child’s participation in the SHSM program. I understand that I may contact the Athletic Trainer
assigned to the School or the Medical Director for SHSM to discuss my child’s care or to discuss any
questions I may have about the program. I consent to the release by GHS/SHSM staff of
information about my child’s medical condition obtained through SHSM Services to physicians,
coaches, and other employees or agents of GHS or to whom I am referred. I also consent to the
release of information about my child’s medical condition to necessary staff at the school, should
accommodations be needed to aid in my child’s education.

I understand that I will not be charged for services rendered on-site by the medical staff, but that I
or my child’s insurance carrier may be charged for services rendered by other healthcare providers.
I consent for information in my child’s medical record to be released for the purpose of filing health
insurance claims with third-party payers. I hereby authorize GHS to submit claims for services
rendered to my child and assign to GHS my rights to any reimbursement for such services.

In consideration for the services provided to my child by SHSM, I hereby release Greenville Health
System, its trustees, officers, employees, and agents from and against any claim, liability, and cause
of action or other expense arising out of the services provided by GHS Sports Medicine Services.

I acknowledge by signing below that I have received a copy of the GHS Notice of Privacy Practices.

I have read and understand the above information and consent to my child’s participation in GHS
Sports Medicine Services.

______________________________  ________________________________
Name of Parent/Guardian (please print)  Signature of Parent/Guardian

______________________________
Name of Student (First, Middle, Last)  ________________
Witness/Date
STEADMAN HAWKINS SPORTS MEDICINE

Athlete’s Name ___________________________ DOB ___________________________ Grade ________
(First / Middle / Last)

School ___________________________________ Sport(s) ____________________________

Guardian(s) _______________________________ Phone #’s (h) ____________ (c) ________
Relationship(s) ____________________________

Address ________________________________________________________________
Street __________________ City __________________ State __ Zip __________

Guardian(s) Email ___________________________ Student Athlete’s Email ____________________________
(For SHSM Emails of Athletic Training/Conditioning Topics)

Emergency contact ___________________________ Phone #’s (h) ____________ (c) ________
(Guardians will be contacted first in case of emergency, please list individual other than listed above)

Ins. Carrier ___________________________ HMO/PPO ___________________________ Group/Policy# __________
(circle one)

Insurance Preferred Network/Provider: yes/no (circle one) Whom ____________________________

<table>
<thead>
<tr>
<th>Does your child have any of the following? (List details as appropriate)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inhaler</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Allergy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe headaches</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Previous injuries/surgeries (month/year) ______________________________________

Is your child on any medication that is taken on a regular basis? (List) ______________________________________

Does your family have a primary care physician? (Name & phone #) ______________________________

Does your family have an orthopaedic doctor? (Name & phone #) ____________________________

My child may take any over-the-counter medication such as Tylenol®/Advil® YES NO

Parent/Guardian Signature ___________________________ Date __________

May 6, 2011
PARENTS'/GUARDIANS/ATHLETE'S Risk Acknowledgement

Athlete’s Name: _____________________________ Date of Birth: _____________________

My/Our child wishes to participate in the athletic program at ____________________________
(name of school) high school. I/We realize that there are risks involved in this participation and attended a group
meeting on __________ where these risks were discussed and explained. The meeting was run
by _____________________________. We had the opportunity to have all our questions answered.
(name of school person)

I/We understand that the risks include a full range of injuries, from minor to severe. I/We recognize the
possibility that my/our child might die, become paralyzed, or suffer brain damage or other serious,
permanent injury as a result of participation in this sports program. I/We realize that neither the
protective equipment and padding used in athletics programs, the safety rules and procedures of the
various sports, the coaching instruction received, nor the sports medicine care provided to athletes will
guarantee safety or prevent all injuries he/she might sustain. I/we agree to accept these risks as a
condition of my/our child’s participation in this program.

ADDITIONAL OR SPECIAL CONDITIONS Risk Acknowledgement

(NOTE: Fill this box out ONLY if your child has a pre-existing condition that may increase risk
of injury and/or illness. If this section does not apply to you, then write “not applicable” or “NA”
in the first space.)

I also realize that my/our child’s ____________________________ creates
(condition) additional risks and I/we discussed these risks with the athletic director, coach(es), and the sports
medicine provider(s) in a meeting on ____________. They explained to me/us that, because of
this condition, the special risks for my/our child are (List all concerns, If you need more room,
write on the back of this form. Write legibly.): ____________________________

I/we understand these concerns and agree to follow all directions and recommendations of my/our
physicians and sports medicine providers in this program. I/we also agree to accept these additional
risks as a part of my/our child’s participation in the program.

Date ___________________________  Signature of Parent/Guardian

Date ___________________________  Signature of Athlete/Participant
Greenville County Schools

Athlete/Parent Concussion Statement

PARENTS AND ATHLETE please initial in each box

Parent Athlete

☐ ☐ I understand that it is my responsibility to report all injuries and illnesses to my athletic trainer.

☐ ☐ I have read and understand the CDC Concussion Fact sheet for parents.

☐ ☐ I have read and understand the CDC Concussion Fact sheet for athletes.

After reading the Concussion fact sheet, I am aware of the following information:

☐ ☐ A concussion is a brain injury that I am responsible for reporting to my athletic trainer, physician, or coach.

☐ ☐ A concussion can affect everyday activities, athletic performance balance, sleep, reaction time, and classroom performance.

☐ ☐ If I suspect a teammate has a concussion I am responsible for reporting the injury to my athletic trainer.

☐ ☐ I will not return to activity on the same day if I have received a blow to the head or body that results in concussion related symptoms.

☐ ☐ Following a concussion the brain needs time to heal. You are much more likely to have another concussion if you return to play prior to your symptoms resolving.

☐ ☐ In rare cases, repeat concussions can cause permanent brain damage or even death.

☐ ☐ I understand that physician clearance, and completion of Return-to-Play Protocol must be completed before an athlete returns to full participation.

Student Athlete Signature ☐ ☐ Parent Signature ☐ ☐ Date ☐ ☐

Printed Name of Student ☐ ☐ Printed Name of Parent ☐ ☐
Concussion Policy

Concussions, a type of traumatic brain injury, are serious and potential life threatening injuries. Continued research has revealed the extent of the injury may be felt, not only in the short term, but years later if not properly identified and treated. In an attempt to maintain the safety and well-being of our student-athletes, we have a policy to identify and manage student-athletes that may suffer a concussion. This policy was developed using recommendations established by the National Athletic Training Association and the 4th International Conference on Concussion in Sport, along with research from the University of North Carolina at Chapel Hill and the University of Pittsburgh.

Definition

Concussions will be defined as a temporary impairment of mental functions, such as, but not limited to, memory, balance, and vision, which results from a direct or indirect injury to the brain. Terminology regarding concussions will no longer include severity (mild, moderate, severe) or the use of slang ("bell rung", "seeing stars", "dinged"). It is important to note that no two concussions are identical and treatment will be determined on a case by case basis to meet the needs of the patient.

Education and Risk Acknowledgement

1. All student-athletes and parents must read the CDC Concussion Fact Sheet and sign the GCSD Student-athlete/Parent Concussion Statement acknowledging that:
   a. they have read and understand the CDC Concussion Fact Sheet.
   b. they accept responsibility for reporting all injuries and illnesses of themselves and others to the school medical staff and/or school personnel, including signs and symptoms of concussion.
2. All GCSD coaches (head coaches and assistant coaches) must sign the GCSD Coaches Concussion Statement acknowledging that:
   a. they have taken and passed the NFHS Concussion in Sport Course.
   b. will encourage student-athletes to report any suspected injuries and illnesses to the medical staff and/or school personnel, including signs and symptoms of concussion.
   c. have read and understood the GCSD concussion policy.
3. The medical staff must acknowledge that they have read and understand the GCSD concussion policy.
4. Head coaches of each respective sport will be required to direct the signing and collection of the aforementioned documents from their staffs and student-athletes. Head coaches will also be responsible for making certain that all required student-athletes have completed the required baseline neurocognitive and balance screening. Student-athletes will not be eligible for participation until their documentation has been received and baseline screening completed.

**Management of Concussions**

1. The management of a concussion begins with pre-season baseline screening.
   a. Screening will involve a graded symptom checklist (GSC) and sideline assessment tool (SCAT3) along with computerized neurocognitive (e.g. ImPACT) and balance (e.g. BESS) assessments.
   b. Student-athletes to be tested include: students entering the 9th and 11th grades, transfer students, and student-athletes who suffered a concussion in the previous year.
   c. All testing must be completed before a student-athlete is eligible for participation.
   d. The following sports are considered at-risk and require baseline testing: baseball, basketball (boys and girls), cheerleading, football, lacrosse (boys and girls), soccer (boys and girls), softball, track and field (field events only), volleyball, and wrestling.
      i. Student-athletes who are not baseline tested will have their post-concussion testing scores compared to currently available normative data.
   e. The medical staff will be responsible for conducting and documenting baseline screening results.

2. Any student-athlete who presents with concussion signs and/or symptoms should be removed from play immediately.
   a. If a team physician or athletic trainer is present, the student-athlete should be referred to that individual for a thorough concussion evaluation.
   b. No student-athlete suspected to have suffered a concussion will return to play on the same day. Student-athletes will only be permitted to return to activity if a team physician or athletic trainer determines that no concussion has occurred and return to play is safe.
   c. If the team physician or athletic trainer is not present, the head coach will be responsible for removing the student-athlete from activity and notifying the student-athlete’s parent(s)/guardian and school athletic trainer.
   d. All student-athletes must have their parent(s)/guardian notified if a concussion is suspected.
      i. Student-athletes with a suspected concussion are only to be released to the direct care of their parent(s)/guardian unless emergency transportation is necessary.
      ii. Instructions regarding the home care of a concussion should always be given to parent(s)/guardians before the student-athlete is released. These instructions should be given verbally and written with any questions addressed.

3. Following the diagnosis of a concussion, the athletic trainer will coordinate with the treating physician to determine a concussion management plan. Only MDs or DOs who have training in the management of concussions can direct the management plan.
   a. Cognitive rest is necessary during the early treatment of concussion and should be included in the concussion management plan.
      i. Activities that worsen symptoms (e.g. school work or computer use) should be withheld until deemed appropriate by the medical staff.
b. Concussion management plans will consist of appropriate post-concussion evaluation, which may include balance and neurocognitive assessments, and a graduated return to play progression.

4. The graduated return to play (RTP) progression can begin once the student-athlete has been symptom free for 24 hours or through the direction of the treating physician.
   a. The graduated RTP protocol consists of 5 stages conducted in the presence of an ATC.
   b. Signs and symptoms should be assessed before, during, and after each stage is conducted.
   c. Each stage must be separated by at least 24 hours.
   d. If a student-athlete becomes symptomatic during the prescribed activity, the test should be stopped immediately. The student-athlete can begin at the previous stage after remaining asymptomatic for 24 hours.
   e. The graduated RTP progression can be found at the end of the policy.
   f. Student-athletes must be cleared by the treating physician to progress to the contact stages of the graduated RTP protocol.
      i. Repeat balance and neurocognitive testing will be considered by the treating physician before advancement.

5. Student-athletes diagnosed with a concussion will not be permitted to return to full unrestricted activity until all of the following conditions have been met:
   a. the student-athlete no longer presents with signs and/or symptoms of concussion
   b. the student-athlete completes the graduated RTP progression while remaining asymptomatic
   c. the student-athlete obtains a written medical release from a physician (MD or DO) trained in concussion management
      i. the written medical release must be documented on a concussion-specific return to participation form.

***Please note: Concussion management is a widely studied topic and advancements in treatment occur frequently. This policy will be updated as needed to stay current with the latest research and methodology.

Acknowledgements
