Lakeview School District

"Home of the Sailors"
2482 Mercer Street
Stoneboro, PA 16153-2799
Phone: 724-376-7911
Fax: 724-376-7910

TO: Parent/Guardian of Football Players
FROM: Business Office
RE: Medical Insurance – 2020-2021 Fall Football Program
DATE: April 27, 2020

In order for your child to participate in Junior High (Grades 7-8) or Varsity Football (Grades 9-12), the following forms **must be completed and returned to the Business Office by Friday July 31, 2020. An athlete will not participate until ALL forms are completed and returned. Athletes turning in forms late will be assessed a one day "no practice" penalty for each day the form is late.**

Student Name ______________________________ Date of Birth ______________

Address ____

Home Phone ________________ Email ______________________ 2020-2021 Grade ________

PARTICIPATING SPORT (check one): ____ Junior High Football ______ Varsity Football

Complete the following and sign below.
______ The above named student is covered under a medical insurance policy. **A COPY OF PARENT/GUARDIAN'S INSURANCE CARD MUST BE ATTACHED TO THIS FORM AS PROOF OF INSURANCE.** (Copies can be made in the Offices.)

Name of Insurance Company - ____________________ Policy Number - ______________

ANY CHANGE IN MEDICAL COVERAGE, SUCH AS LOSS OF INSURANCE COVERAGE, MUST BE REPORTED TO THE BUSINESS OFFICE AS SOON AS IT OCCURS.

______ The above named student is not presently covered under any medical insurance policy. An individual policy will be purchased prior to July 31, 2020 (date all forms are due). **Proof of purchase must be provided to the Business Office.**

** Football insurance coverage will be available for purchase through the Business Office the first of July 2020. **The completed insurance form along with payment must be returned to the Business Office. THIS INSURANCE PLAN COVERS FOOTBALL ONLY.****

NOTE: STUDENTS WHO DO NOT HAVE MEDICAL INSURANCE WILL NOT BE PERMITTED TO PRACTICE OR PLAY FOOTBALL. PARENT/GUARDIAN WILL BE RESPONSIBLE FOR ALL FOOTBALL RELATED MEDICAL EXPENSES. PLEASE CALL THE BUSINESS OFFICE WITH ANY QUESTIONS. THANK YOU.

______________________________ ______________________________
Signature (Parent, Guardian) Date

Lakeview School District

"Home of the Sailors"
2482 Mercer Street
Stoneboro, PA 16153-2799
Phone: 724-376-7911
Fax: 724-376-7910

Please make sure a copy of the student-athlete's insurance card it attached to this packet.

PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION

INITIAL EVALUATION: Prior to any student participating in Practices, Inter-School Practices, Scrimmages, and/or Contests, at any PIAA member school in any school year, the student is required to (1) complete a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE); and (2) have the appropriate person(s) complete the first six Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, and 5 by the student and parent/guardian; and Section 6 by an Authorized Medical Examiner (AME), those Sections must be turned in to the Principal, or the Principal's designee, of the student's school for retention by the school. The CIPPE may not be authorized earlier than June 1st and shall be effective, regardless of when performed during a school year, until the latter of the next May 31st or the conclusion of the spring sports season.

SUBSEQUENT SPORT(S) IN THE SAME SCHOOL YEAR: Following completion of a CIPPE, the same student seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) in the same school year, must complete Section 7 of this form and must turn in that Section to the Principal, or Principal's designee, of his or her school. The Principal, or the Principal's designee, will then determine whether Section 8 need be completed.

SECTION 1: PERSONAL AND EMERGENCY INFORMATION

PERSONAL INFORMATION

Student's Name ____________________ Male/Female (circle one)

Date of Student's Birth: ___/___/_____ Age of Student on Last Birthday: ____ Grade for Current School Year: ____

Current Physical Address ____________________

Current Home Phone # (   )__________ Parent/Guardian Current Cellular Phone # (   )__________

Fall Sport(s): __________ Winter Sport(s): __________ Spring Sport(s): __________

EMERGENCY INFORMATION

Parent's/Guardian's Name____________________ Relationship __________

Address ____________________ Emergency Contact Telephone # (   )__________

Secondary Emergency Contact Person's Name ____________________ Relationship __________

Address ____________________ Emergency Contact Telephone # (   )__________

Medical Insurance Carrier____________________ Policy Number__________

Address ____________________Telephone # (   ) __________

Family Physician's Name____________________, MD or DO (circle one)

Address ____________________Telephone # (   ) __________

Student's Allergies____________________

Student's Health Condition(s) of Which an Emergency Physician or Other Medical Personnel Should be Aware__________

____

____

____

Student's Prescription Medications and conditions of which they are being prescribed __________

____

SECTION 2: CERTIFICATION OF PARENT/GUARDIAN

The student's parent/guardian must complete all parts of this form.

A. I hereby give my consent for ____ born on ______________ who turned ______ on his/her last birthday, a student of ____ School and a resident of the ____ public school district, to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 20____ - 20____ school year in the sport(s) as indicated by my signature(s) following the name of the said sport(s) approved below.

Fall Sports	Signature of Parent or Guardian
Cross Country	
Field Hockey	
Football	
Golf	
Soccer	
Girls' Tennis	
Girls' Volleyball	
Water Polo	
Other	

Winter Sports	Signature of Parent or Guardian
Basketball	
Bowling	
Competitive Spirit Squad	
Girls' Gymnastics	
Rifle	
Swimming and Diving	
Track & Field (Indoor)	
Wrestling	
Other	

Spring Sports	Signature of Parent or Guardian
Baseball	
Boys' Lacrosse	
Girls' Lacrosse	
Softball	
Boys' Tennis	
Track & Field (Outdoor)	
Boys' Volleyball	
Other	

B. Understanding of eligibility rules: I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in Inter-School Practices, Scrimmages, and/or Contests involving PIAA member schools. Such requirements, which are posted on the PIAA Web site at www.piaa.org, include, but are not necessarily limited to age, amateur status, school attendance, health, transfer from one school to another, season and out-of-season rules and regulations, semesters of attendance, seasons of sports participation, and academic performance.

Parent's/Guardian's Signature ____ Date____/____/_____

C. Disclosure of records needed to determine eligibility: To enable PIAA to determine whether the herein named student is eligible to participate in interscholastic athletics involving PIAA member schools, I hereby consent to the release to PIAA of any and all portions of school record files, beginning with the seventh grade, of the herein named student specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, health records, academic work completed, grades received, and attendance data.

Parent's/Guardian's Signature ____ Date____/____/_____

D. Permission to use name, likeness, and athletic information: I consent to PIAA's use of the herein named student's name, likeness, and athletically related information in video broadcasts and re-broadcasts, webcasts and reports of Inter-School Practices, Scrimmages, and/or Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

Parent's/Guardian's Signature ____ Date____/____/_____

E. Permission to administer emergency medical care: I consent for an emergency medical care provider to administer any emergency medical care deemed advisable to the welfare of the herein named student while the student is practicing for or participating in Inter-School Practices, Scrimmages, and/or Contests. Further, this authorization permits, if reasonable efforts to contact me have been unsuccessful, physicians to hospitalize, secure appropriate consultation, to order injections, anesthesia (local, general, or both) or surgery for the herein named student. I hereby agree to pay for physicians' and/or surgeons' fees, hospital charges, and related expenses for such emergency medical care. I further give permission to the school's athletic administration, coaches and medical staff to consult with the Authorized Medical Professional who executes Section 6 regarding a medical condition or injury to the herein named student.

Parent's/Guardian's Signature ____ Date____/____/_____

F. CONFIDENTIALITY: The information on this CIPPE shall be treated as confidential by school personnel. It may be used by the school's athletic administration, coaches and medical staff to determine athletic eligibility, to identify medical conditions and injuries, and to promote safety and injury prevention. In the event of an emergency, the information contained in this CIPPE may be shared with emergency medical personnel. Information about an injury or medical condition will not be shared with the public or media without written consent of the parent(s) or guardian(s).

Parent's/Guardian's Signature ____ Date____/____/_____

SECTION 3: UNDERSTANDING OF RISK OF CONCUSSION AND TRAUMATIC BRAIN INJURY

What is a concussion?
A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body.
- Can change the way a student's brain normally works.
- Can occur during Practices and/or Contests in any sport.
- Can happen even if a student has not lost consciousness.
- Can be serious even if a student has just been "dinged" or "had their bell rung."

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

What are the symptoms of a concussion?
Concussions cannot be seen; however, in a potentially concussed student, ***one or more*** of the symptoms listed below may become apparent and/or that the student "doesn't feel right" soon after, a few days after, or even weeks after the injury.

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

What should students do if they believe that they or someone else may have a concussion?

- **Students feeling any of the symptoms set forth above should immediately tell their Coach and their parents.** Also, if they notice any teammate evidencing such symptoms, they should immediately tell their Coach.
- **The student should be evaluated.** A licensed physician of medicine or osteopathic medicine (MD or DO), sufficiently familiar with current concussion management, should examine the student, determine whether the student has a concussion, and determine when the student is cleared to return to participate in interscholastic athletics.
- **Concussed students should give themselves time to get better.** If a student has sustained a concussion, the student's brain needs time to heal. While a concussed student's brain is still healing, that student is much more likely to have another concussion. Repeat concussions can increase the time it takes for an already concussed student to recover and may cause more damage to that student's brain. Such damage can have long term consequences. It is important that a concussed student rest and not return to play until the student receives permission from an MD or DO, sufficiently familiar with current concussion management, that the student is symptom-free.

How can students prevent a concussion? Every sport is different, but there are steps students can take to protect themselves.

- Use the proper sports equipment, including personal protective equipment. For equipment to properly protect a student, it must be:

  The right equipment for the sport, position, or activity;
  Worn correctly and the correct size and fit; and
  Used every time the student Practices and/or competes.

- Follow the Coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

If a student believes they may have a concussion: Don't hide it. Report it. Take time to recover.

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Student's Signature ______________________________ Date____/____/_____

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Parent's/Guardian's Signature ______________________________ Date____/____/_____

SECTION 4: UNDERSTANDING OF SUDDEN CARDIAC ARREST SYMPTOMS AND WARNING SIGNS

What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

How common is sudden cardiac arrest in the United States?

There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- dizziness
- lightheadedness
- shortness of breath
- difficulty breathing
- racing or fluttering heartbeat (palpitations)
- syncope (fainting)
- fatigue (extreme tiredness)
- weakness
- nausea
- vomiting
- chest pains

These symptoms can be unclear and confusing in athletes. Often, people confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

What are the risks of practicing or playing after experiencing these symptoms?

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who have SCA die from it.

Act 59 – the Sudden Cardiac Arrest Prevention Act (the Act)

The Act is intended to keep student-athletes safe while practicing or playing. The requirements of the Act are:

Information about SCA symptoms and warning signs.

- Every student-athlete and their parent or guardian must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.
- Schools may *also* hold informational meetings. The meetings can occur before each athletic season. Meetings may include student-athletes, parents, coaches and school officials. Schools may also want to include doctors, nurses, and athletic trainers.

Removal from play/return to play

- Any student-athlete who has signs or symptoms of SCA must be removed from play. The symptoms can happen before, during, or after activity. Play includes all athletic activity.
- Before returning to play, the athlete must be evaluated. Clearance to return to play must be in writing. The evaluation must be performed by a licensed physician, certified registered nurse practitioner, or cardiologist (heart doctor). The licensed physician or certified registered nurse practitioner may consult any other licensed or certified medical professionals.

I have reviewed and understand the symptoms and warning signs of SCA.

______________________ Signature of Student-Athlete	______________________ Print Student-Athlete's Name	Date____/____/_____
______________________ Signature of Parent/Guardian	______________________ Print Parent/Guardian's Name	Date____/____/_____

Student's Name ______________________ Age________ Grade________

SECTION 5: HEALTH HISTORY

Explain "Yes" answers at the bottom of this form.
Circle questions you don't know the answers to.

#	Question	Yes	No
1.	Has a doctor ever denied or restricted your participation in sport(s) for any reason?	☐	☐
2.	Do you have an ongoing medical condition (like asthma or diabetes)?	☐	☐
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5.	Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6.	Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8.	Does your heart race or skip beats during exercise?	☐	☐
9.	Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ Heart murmur ☐ High cholesterol ☐ Heart infection		
10.	Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	☐	☐
11.	Has anyone in your family died for no apparent reason?	☐	☐
12.	Does anyone in your family have a heart problem?	☐	☐
13.	Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?	☐	☐
14.	Does anyone in your family have Marfan syndrome?	☐	☐
15.	Have you ever spent the night in a hospital?	☐	☐
16.	Have you ever had surgery?	☐	☐
17.	Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a Practice or Contest? If yes, circle affected area below:	☐	☐
18.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐

Head	Neck	Shoulder	Upper arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper back	Lower back	Hip	Thigh	Knee	Calf/shin	Ankle	Foot/ Toes

#	Question	Yes	No
20.	Have you ever had a stress fracture?	☐	☐
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22.	Do you regularly use a brace or assistive device?	☐	☐
23.	Has a doctor ever told you that you have asthma or allergies?	☐	☐
24.	Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	☐	☐
25.	Is there anyone in your family who has asthma?	☐	☐
26.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
27.	Were you born without or are your missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28.	Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30.	Have you ever had a herpes skin infection?	☐	☐
	CONCUSSION OR TRAUMATIC BRAIN INJURY		
31.	Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	☐	☐
32.	Have you been hit in the head and been confused or lost your memory?	☐	☐
33.	Do you experience dizziness and/or headaches with exercise?	☐	☐
34.	Have you ever had a seizure?	☐	☐
35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37.	When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39.	Have you had any problems with your eyes or vision?	☐	☐
40.	Do you wear glasses or contact lenses?	☐	☐
41.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42.	Are you unhappy with your weight?	☐	☐
43.	Are you trying to gain or lose weight?	☐	☐
44.	Has anyone recommended you change your weight or eating habits?	☐	☐
45.	Do you limit or carefully control what you eat?	☐	☐
46.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐
	FEMALES ONLY	☐	☐
47.	Have you ever had a menstrual period?	☐	☐
48.	How old were you when you had your first menstrual period?	________	
49.	How many periods have you had in the last 12 months?	________	
50.	Are you pregnant?	☐	☐

#'s	Explain "Yes" answers here:

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature ________________________________ Date____/____/_____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature ________________________________ Date____/____/_____

SECTION 6: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER

Must be completed and signed by the Authorized Medical Examiner (AME) performing the herein named student's comprehensive initial pre-participation physical evaluation (CIPPE) and turned in to the Principal, or the Principal's designee, of the student's school.

Student's Name ______________________________ Age__________ Grade________

Enrolled in ______________________________ School Sport(s) ______________________________

Height_______ Weight_____ % Body Fat (optional) ______ Brachial Artery BP_____/_____ (_____/_____ , _____/_____) RP_______

If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student's primary care physician is recommended.

Age 10-12: BP: >126/82, RP: >104; **Age 13-15:** BP: >136/86, RP >100; **Age 16-25:** BP: >142/92, RP >96.

Vision: R 20/_____ L 20/_____ Corrected: YES NO (circle one) Pupils: Equal_____ Unequal_____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		☐ Heart murmur ☐ Femoral pulses to exclude aortic coarctation ☐ Physical stigmata of Marfan syndrome
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student's parent/guardian in Section 2 of the PIAA Comprehensive Initial Pre-Participation Physical Evaluation form:

☐ **CLEARED** ☐ **CLEARED**, with recommendation(s) for further evaluation or treatment for:______________________________

☐ **NOT CLEARED** for the following types of sports (please check those that apply):

☐ COLLISION ☐ CONTACT ☐ NON-CONTACT ☐ STRENUOUS ☐ MODERATELY STRENUOUS ☐ NON-STRENUOUS

Due to ______________________________

Recommendation(s)/Referral(s) ______________________________

AME's Name (print/type) ______________________________ License #______________

Address______________________________ Phone (   )______________

AME's Signature__________________MD, DO, PAC, CRNP, or SNP *(circle one)* Certification Date of CIPPE ___/___/___

PARENT/ STUDENT- ATHLETE ASSURANCE FORM

The Parent/Student Athlete handbook was compiled to help parents and student athletes understand the rules and regulations required to participate in interscholastic sports. It is hoped that the listing of various proven practices and procedures presented in this handbook, will promote a more efficient operation and enjoyable experience through the interscholastic athletic program at Lakeview School District.

Each student athlete and parent/guardian needs to sign the slip below acknowledging review and understanding of the information provided in the Parent/Student Athlete Handbook on the District's website (under forms and links). Prior to participation, athletes are required to submit the signed form to the Coach.

Acknowledgement
I have reviewed the Parent/Student Athlete Handbook material presented on the District's website.

Parent/Guardian Signature: ______________________________ Date: ________

Parent/Guardian Name: ____
(Please print)

Student Athlete Signature: ______________________________ Date: ________

Student Athlete Name: ______________________________ Grade: _______
(Please print)

Parent/Student Athlete Concussion Awareness & Management Acknowledgement

The concussion awareness and management protocol is designed to inform parents and student athletes on the importance of ensuring athlete safety by providing guidance for prevention, evaluation and management of concussions/ traumatic brain injuries.

Each student athlete and parent/guardian must sign below acknowledging receipt and understanding of the information provided in the concussion awareness and management protocol. Prior to participation, athletes are required to submit the signed acknowledgement to the Coach, Athletic Trainer or Athletic Director.

Acknowledgement
I have received a copy of the Concussion Awareness & Management Protocol and have reviewed the information.

Parent/Guardian Signature: ______________________________ Date: __________

Parent/Guardian Name: ___________________________________
(please print)

Student Athlete Signature: ______________________________ Date: __________

Student Athlete Name: ___________________________________
(please print)

LAKEVIEW SCHOOL DISTRICT

CONCUSSION AWARENESS & MANAGEMENT PROTOCOL

Lakeview School District acknowledges the possibility and severity of concussions and head injuries sustained by students who participate in school-sponsored physical activities and strive to properly recognize and manage signs or symptoms of such injuries.

All information is in accordance with the PA Senate Bill 200-Safety in Youth Sports Act and is based on PIAA and NFHS guidelines, ImPACT test recommendations, and Brain Injury Association of Pennsylvania, Inc recommendations.

To better recognize concussions and head injuries, the following procedures are to be followed by Lakeview School District staff:

1. Designated District staff, including paid and volunteer coaches, must complete one approved concussion training each school year (valid July 1-June 30) and submit a completion letter or certification to the District Administration Office. Approved trainings are offered through the Centers for Disease Control and Prevention, the National Federation of State High School Associations, and the Pennsylvania Departments of Health or Education. Coaches, paid or volunteer, are not permitted to coach an athletic activity until an approved training course is completed and completion documentation is on file in the District Office.
2. Students exhibiting any signs or symptoms of a concussion or head injury during school-sponsored classes, extracurricular activity, or interscholastic athletic activity shall be immediately removed from activity and evaluated by a licensed health care professional trained in the treatment and management of concussion prior to returning to physical activity.

   Signs of Concussion:
   (Can be observed by District Staff, including Coaches or Athletic Trainer, School Nurse, Game Officials, Licensed Physician, Licensed Physical Therapist)
   1. Appears to be dazed, stunned, or disoriented
   2. Is confused, forgets play, or demonstrates short term memory difficulty
   3. Slurs words
   4. Moves clumsily-exhibiting difficulty with balance or coordination
   5. Answers questions slowly
   6. Shows behavior or personality change
   7. Changes in level of consciousness (even temporarily)

   Symptoms of Concussion:
   1. Headache
   2. Nausea
   3. Balance difficulty or dizziness
   4. Double or changes in vision
   5. Light or noise sensitivity
   6. Feeling sluggish or foggy
   7. Sleep disturbance
   8. Concentration or memory problems

The following Concussion Management procedures are to be followed by Lakeview School District staff after a student who displays signs or symptoms of a concussion is removed from an activity:

1. The student must seek emergency medical treatment if the following occur: vomiting and/or seizure, consciousness level alters for any period of time, or direct neck pain is associated with the injury.
2. A designated District staff member must contact the student's parents/guardians and provide information of the incident and suspected concussion/ head injury. The staff member will also provide the parents/guardians with information on signs/symptoms of a head injury and continuing care of a person with a concussion or head injury.
   - The Home Instruction/ Parental Awareness form will be covered and given to the parent/guardian of the injured student within 24 hours of the **reporting** of the injury.
3. All appropriate District staff shall be notified of the event, including but not limited to the School Nurse, School Psychologist, School Counselor, Special Education Coordinator, student's teachers, Athletic Director/Athletic Trainer.
4. The student must be evaluated by an appropriate medical professional who is trained in treatment and management of concussions.
5. After diagnosis by a trained medical professional, the student must provide written documentation to the District's Athletic Trainer and School Nurse. *Documentation must include any specific academic accommodations. Complete physical, cognitive, emotional, and social rest is advised while a student experiences symptoms and signs of a concussion. It is recommended that student's mental exertion, overstimulation, cell phone or computer usage, testing, video gaming, and multi-tasking be kept to a minimum.
6. A follow-up ImPACT test will be administered by the Athletic Trainer or School Nurse within 24-48 hours post injury/reporting of the injury.
   - If the 24-48 hour follow-up ImPACT test is passed and the student is asymptomatic, a two day grace period will take place. During these two days the student will be monitored during physical activity with limitations placed on contact drills. These two days must take place during regular practice times and may not be an event/game day.
   - If the student passes this ImPACT test but is symptomatic they will need to be seen by his/her physician once asymptomatic to begin the 5-Day return to play protocol (RTPP). Once the student completes the RTPP he/she will be permitted to participate/ play as long as the final day is not an event/game day.
7. Subsequent ImPACT follow-up tests will be done weekly (every 7 days) until baseline scores are achieved and reviewed by a trained medical professional.
   - If ImPACT is failed two weeks in a row, the student will be advised to make an appointment with a UPMC concussion clinic to be seen by a neuropsychologist.
     - UPMC Sports Medicine Concussion Program- 3200 South Water St Pittsburgh Pa 15203
     - (P) 412-432-3681
     - UPMC Lemieux Sports Complex- 8000 Cranberry Springs Dr, Cranberry Twp, PA 16066
     - (P) 724-720-3000
8. When student is asymptomatic at rest and a written clearance is received from a concussion trained medical professional, the injured student may begin a graduated return-to-physical activity protocol supervised by the District Athletic Trainer, Licensed Physical Therapist, or licensed health care provider trained in the evaluation and management of concussions.

   Supervised Return- to-Physical Activity Progression(General):

   Day 1 Student shall complete a full day of normal cognitive activity (school day, studying for tests, watching practice, socializing with peers, video games) without recurrence of any signs or symptoms.

   Day 2 If symptoms did not return on Day 1, student shall perform light aerobic exercise, which includes walk/jog, swimming or stationary cycling (no resistance training) for 10-15 minutes. The objective of day 2 is to increase heart rate without symptoms recurring.

   Day 3 If symptoms did not return on Day 2, student shall participate in specific physical activity such as skating

or running (no head impact activities). The objective of day 3 is to add movement while increasing heart rate.

Day 4 If symptoms did not return on Day 3, student may perform non-contact training drills and may initiate progressive resistance training.

Day 5 If symptoms did not return on Day 4, student may participate in normal training activities. The objective of this step is to restore student's confidence and for the supervisor to assess functional skills. If no symptoms are present, the student may return to normal exertion and physical activity without limitation. Students in athletic activities must complete one full day of practice prior to participating in a game.

*If concussion symptoms recur during the progression steps, the student will wait 24 hours and return to the previous level of activity that caused no symptoms. The licensed medical professional shall be contacted regarding the student's symptom relapse.

*Temporary learning support accommodations may be recommended by the licensed medical professional trained in concussion management. Rest is essential in healing concussions or head injuries. Memory, attention span, concentration, and speed of processing significantly impact learning. A concussed student may exacerbate symptoms and delay recovery if exposed to a stimulating school environment. Accordingly, the following steps shall be taken as recommended by a physician during concussion recovery:

1. Student shall take rest breaks as needed.
2. A shortened school day may be necessary for the student.
3. More time to take tests or complete assignments may need to be considered.
4. Student may need additional help with schoolwork.
5. Student shall spend less time on the computer, reading, and writing.
6. Avoid crowded hallways, by dismissing from each class early.
7. No standardized testing shall be administered to the student during the initial recovery window of 2-4 weeks.

Return-to-physical activity will resume for a concussed student upon completion of the following steps:

1. Written clearance by a licensed medical professional trained in evaluation and treatment of concussions is received by the District School Nurse and Athletic Trainer.
2. The injured student is symptom free for 24 hours without medication.
3. ImPACT scores are equivalent to baseline.
4. The progression steps for return-to-physical activity are complete.

A written physician clearance alone will not suffice for a student to participate in physical activity/ sporting event; the 5-day RTP Protocol must be completed without any reoccurrence of symptoms for the athlete to be fully cleared.
The school district's Athletic Trainer/ School Nurse have the final say in clearance for a concussion if more recovery time is deemed needed.

Any coach who violates the removal of an athlete exhibiting signs or symptoms of a concussion or head injury or returns an athlete to play who has not completed the required steps following a diagnosed concussion will be suspended from coaching any athletic activity for the remainder of the season for the first violation. A second violation from the same coach will result in suspension from coaching any athletic activity for the remainder of the season and the next season. For a third violation, the coach will receive permanent suspension from coaching any athletic activity.

Various forms are available from ImPACT for physician and/or School Nurse/Athletic Trainer completion. Such forms are included with this protocol information for parent/guardian convenience. The forms and other helpful information can also be found on the ImPACT website at http://impacttest.com/faq#faq_62.

Day of Injury- Follow the home care instructions and monitor the athlete for worsening symptoms

24-48 Hours after Injury- Take post injury ImPACT test (1).

Passes ImPACT & Asymptomatic

The athlete will be granted approval from the District's Athletic Trainer, however will have a 2 day grace period of limited practice and contact drills (must be active practice days).

- Day 1- Grace Period 50% of activity (Cannot be a game day)
- Day 2- Grace Period 75% of activity(Cannot be a game day)

Passes ImPACT & Symptomatic

The athlete must wait until all symptoms have subsided and have a physicians approval to begin the 5-day RTP protocol

- Day 1- Full day of regular cognitive activity
- Day 2- Light Cardio Exercise
- Day3- Sport Specific Activity/ Moderate Cardio
- Day 4- Non Contact Training Drills/ Resistance Training
- Day 5- Normal day of training activities (as long as not on a game/match day)

Fails ImPACT (1)

The athlete must now wait 7 days to retest. During that time the athlete is to cease sports and gym participation (No physical Activity).

Passes Retake ImPACT test after 7 days

Need to see a physician for clearance to begin the 5-day RTPP

- Day 1- Full day of regular cognitive activity
- Day 2- Light Cardio Exercise
- Day 3- Sport Specific Activity/ Moderate Cardio
- Day 4- Non Contact Training Drills/ Resistance Training
- Day 5- Normal day of training activities (as long as not on a game/match day

Fails Retake ImPACT test (2) after 7 days

Referral to the UPMC Concussion Clinic

Must receive clearance from the UPMC Concussion Clinic to begin RTPP.

- Day 1- Full day of regular cognitive activity
- Day 2- Light Cardio Exercise
- Day3- Sport Specific Activity/ Moderate Cardio
- Day 4- Non Contact Training Drills/ Resistance Training
- Day 5- Normal day of training activities (as long as not on a game/match day