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.**

Important Information:

- Please refer to COVID information from Center for Disease Control and Prevention (CDC) and Delaware Department of Public Health (DPH) for the 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).
- **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.**

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 qualified health care professional's signature (RN/ATC). **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 its 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 the form prior to visit.

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

Sex _____ 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

GENERAL QUESTIONS	Yes	No
1. Do you have any concerns you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU:	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, *or* skip beats (irregular beats) during exercise?		
7. Has a doctor told you that you have any heart issues?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiogram (EKG) or echocardiogram?		
9. Do you get light headed or feel shorter of breath more than your friends during exercise ?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy(ARVC), long QT syndrome (LQTS),. short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker , or implanted defibrillator before age 35?		
BONE AND JOINT QUESTIONS	Yes	No
14. Since you were last cleared to play sports, have you had a new injury to a bone, muscle, ligament or tendon?		
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. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		

	Yes	No
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problem?		
21. Have you ever had numbness, tingling, weakness in your arms or leg or been unable to move your arms or legs after being hit or falling?		
22 .Have you ever become ill during exercising in the heat?		
23. Do you or someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have problems with your eyes or vision?		
25. Do you worry much about your weight?		
26. Are you trying or has anyone recommended you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY 29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period? _____		
31. When was your most recent menstrual period? _____		
32. How many periods have you *had* in the last 12 months? _____		

Answer "Yes" if it ever occurred. Explain "yes" answers here:

_____
_____
_____
_____
_____
_____
_____
_____
_____

SCHOOL QUALIFIED HEALTHCARE PROFESSIONAL (QHP): (RN/ATC)
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 are 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: _____

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-enhancing supplement?
- Have you ever taken any supplements to help you gain or lose weight or improve your performance?
- Do you wear a seat bell, use a helmet, and use condoms?

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

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 Staphylococcus 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 a cardiologist for abnormal cardiac history or examination findings, or a combination of these.

HEALTHCARE PROVIDER (MD/DO, NP, PA): THIS FORM [pg4] MUST BE USED IN CONJUNCTION WITH THE MEDICAL HISTORY FORM [pg3] AND MEDICAL CARD [pg5]. THIS FORM [pg. 4] MUST BE SIGNED BY HEALTH CARE PROVIDER (MD/DO, NP, PA).

Comments:

_____

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

Name of Health Care Provider (MD/DO, NP, PA) print or type: Nemishh Mehta, MD / Shilpa Mehta, MD Date of Exam: _____

Address: 1400 Peoples Plaza, Suite 201, Newark, DE 19702 Phone: (302) 392-2200

Signature of Health Care Provider (MD/DO, NP, PA): _____ Date of Clearance: _____

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: Nemishh Mehta, MD / Shilpa Mehta, MD Phone: (302) 392-2200

Hospital Preference: _____ Insurance: _____

Policy #: _____ Group: _____ Phone: _____

Section 2: Medical Information

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: Verification of Clearance for Participation

Comments: _____

_____

Qualified Health Care Professional's (QHP) Signature after reviewing PPE: _____ (RN/ATC)

Date: _____

***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:** _____*

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://education.delaware.gov/diaa/health_and_safety/concussions_and_sudden_cardiac_arrest/
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.