

**HOLY SPIRIT HIGH SCHOOL ATHLETICS
SPORTS PHYSICAL INSTRUCTIONS**

Attached you will find the six part packet that needs to be completed in order to participate in any interscholastic athletic practice and/or competition. Please be advised that ALL areas of each page must be completed, signed and dated.

All forms must be completely filled out. Incomplete forms will be returned and students will not be permitted to participate until all missing areas are complete and approved by the school.

NO EXCEPTIONS!

Student Name: _____ Sport: _____

High School Year: _____ Date: _____

1. **Athletic Training Emergency Form** – This form must be completed and signed each time a new sport is played. Reviewed by Athletic Office.
2. **NJSIAA Steroid Testing Policy** – This form is valid for one school year. Reviewed by Athletic Office.
3. **NJSIAA Concussion Acknowledgement Form** – This form is valid for one school year. Reviewed by the Athletic Office.
4. **PART A: Health History Questionnaire** – This form must be completed for each athletic season. Please make sure that all areas are complete, including signature(s) and dates. Reviewed by the Nurse's Office.
5. **PART B: Physical Examination Form** – Physicals are valid for one calendar year from the date of the exam. Reviewed by the Nurse's office. Completed packets must be returned to the Coach before practice begins for the season.
6. **Athletic Permission Form** – This form must be completed and signed each time a new sport is played. Please make sure that all areas are completed, including the emergency contact area, name of sport, signature(s) and date by both parent and student.

All forms must be completely filled out. Incomplete forms will be returned and students will not be permitted to participate until all missing areas are complete and approved by the school.

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

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

Part A: HEALTH HISTORY QUESTIONNAIRE

Today's Date: _____ Date of Last Sports Physical: _____

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

EMERGENCY CONTACT INFORMATION

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

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

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

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

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

List all medications here:

Medication Name	Dosage	Frequency

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. **Females only:**

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

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

8. **Males only:**

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

PARENT/GUARDIAN SIGNATURE

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

Signature, Parent/Guardian or Student Age 18

Date of Signature:

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

ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

Part B: Physical Evaluation Form

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

-STUDENT INFORMATION-

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

- EXAMINING PHYSICIAN/PROVIDER CONTACT INFORMATION-

If conducted by school physician check here

Name: _____ Phone: _____ Fax: _____
 Address: _____ City/State/Zip: _____

- FINDINGS OF PHYSICAL EVALUATION -

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

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

Most recent immunizations and dates administered:

Medications currently prescribed, with dose and frequency:

Medication Name	Dosage	Frequency

Additional observations:

General Diagnosis:

General Recommendations:

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

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

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

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

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

___ CONTACT/COLLISION
___ LIMITED CONTACT

___ NON-CONTACT/STRENUOUS
___ NON-CONTACT/NON-STRENUOUS

Limitations due to: _____

NOTES TO THE EXAMINING PROVIDER

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

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

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT

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

Effects of physiologic maneuvers on heart sounds

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

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

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

Physical Stigmata of Marfan's Syndrome

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

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

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

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

PHYSICIAN'S/PROVIDER'S SIGNATURE: _____

Today's Date: _____

Date of Exam: _____

RESERVED FOR SCHOOL DISTRICT USE

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

History and Physical Reviewed By: _____ Date: _____

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

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

Letter of notification is attached.

OR

Parent notification indicates that:

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

Reason(s) for Disapproval: _____

HOLY SPIRIT HIGH SCHOOL ATHLETIC PERMISSION FORM

Please fill in all blank spaces on all pages of this form as it is retained in two separate offices.

Date: _____ Date of Last Physical: _____
Student's Name: _____ Sex: _____ Age: _____
Date of Birth: _____ Sport: _____
Home Phone: _____ Grade: _____
Physician: _____ Phone: _____ Fax: _____
Emergency Contact Information:
Name: _____ Relationship: _____
Phone: Home _____ Cell: _____ Work: _____]

(If a work phone is a casino, please give department and/or extension)

Please be advised that a form must be submitted for each sport in which the student participates.

I/We, the undersigned, parent/guardian of _____, hereby give consent for my son/daughter/ward to participate in interscholastic _____ for Holy Spirit High School. I am aware of the physical dangers in interscholastic athletic practices and games, and of the dangers involved in traveling to and from such events. I/We recognize that such activity involves the potential for injury, which is inherent in all sports. It is further acknowledged that even with proper supervision and/or coaching, the use of suitable and adequate protective equipment, premises kept in good condition and free from hazards, and strict observation of rules, injuries are still a possibility. On rare occasions, these injuries can be so severe as to result in total disability, paralysis or even death. I/We acknowledge that I/we have read and understand this warning. It is recognized that Holy Spirit High School is not responsible to pupils, parents or guardians for any accidents or injuries that may occur.

The undersigned further acknowledges that participants will be required to use after school time for practices and competitions. In some cases, the competition and/or practices are held away from school grounds. It is required that each participant pass a complete physical exam given by their own physician. Physical exams are good for one calendar year (365 days). This exam must be good for the entire season and cannot expire during the season. The student will be covered under the school sponsored accident insurance program and must pass the minimum requirements as set by the New Jersey State Interscholastic Athletic Association and Holy Spirit High School.

The undersigned further gives consent for school authorities to release the participant's grades to colleges and universities as a prospective applicant for those schools and to the "Press" as a possible candidate to their All-American team selections.

The undersigned hereby empowers and directs the athletic trainer, coach, staff, and school authorities to authorize emergency medical treatment to my child in any case where such treatment is reasonably necessary in the judgment of the athletic trainer, coach, staff, or school authorities. I/We understand that during school athletic events, contests, practice seasons, and activities, there are many occasions when a physician is not present. I hereby authorize the athletic trainer, coach, staff, or school authorities to render first aid if an accident or injury takes place under the above circumstances.

HOLY SPIRIT HIGH SCHOOL ATHLETIC TEAM RULES

1. The proper conduct of all team members is a primary goal in athletics. Violations of acceptable standards of good conduct will bring disciplinary action in proportion to the severity of the offense.
2. Student athletes may not possess or use alcoholic beverages, narcotics, tobacco, marijuana, or other controlled substances, as defined by the laws of the State of New Jersey, in the school, on the school grounds or school bus. Such action will result in immediate or prompt dismissal from that team.
3. Attendance at all practices is necessary for all team members to attain success. There are legitimate reasons for absence, but they should be minimal and permission to miss practice must be cleared through the head coach or athletic supervisor.
4. An athlete will not be permitted to practice or play in a contest if the athlete has been absent from school that day, unless his absence has been cleared through the Vice Principal or, in his absence, the Supervisor of Athletics.
5. Athletes will not be permitted to practice or play while on suspension (in or out of school).
6. Athletes must meet all eligibility requirements as set by the Holy Spirit High School and the New Jersey Interscholastic Athletic Association. Eligibility requirements are listed in your student guidebook.
7. Any, and all injuries, must be reported to the athletic trainer and coach as soon as possible.
8. Athletes and managers may not drive to any away athletic contest with anyone other than on the team bus, unless a written note of permission signed by the parent/guardian is given to the Athletic Director and/or coach at least 24 hours before the athletic contest in question, unless there is an unavoidable emergency. A student may only be driven by a parent/guardian.
9. Initiation and hazing at any time are illegal and forbidden. All hazing incidents must be reported to the Director of Athletics. Appropriate disciplinary action will be taken.
10. Destruction of property; public, private, or school, will not be tolerated. Violators will be promptly disciplined and possibly removed from the team.
11. Betting and/or gambling are strictly forbidden. Appropriate disciplinary action will be taken.
12. Forgery of any portion of this document may result in forfeiture of participating in the athletic program.

STRENGTH AND CONDITIONING PROGRAM RECOMMENDATIONS

It is strongly recommended that your son/daughter participate in in-season and out-of-season strength and conditioning programs to help prevent injuries and improve athletic performance.

EQUIPMENT RESPONSIBILITY

1. Any and all equipment that is issued to your child becomes his/her responsibility.
2. If equipment is not returned at the close of the season, your son/daughter will be held accountable for that equipment.
3. If the athletic equipment is lost or stolen from your child during the season, the responsibility for that equipment still remains with your child and he/she may be held accountable for it, depending upon circumstances.

I have reviewed all the information on this form, and agree to the participation of my son/daughter in athletics under the conditions stated.

Student Signature Date Parent/Guardian Signature Date

**HOLY SPIRIT HIGH SCHOOL
ATHLETIC TRAINING EMERGENCY FORM**

SPORT GRADE _____

STUDENT'S NAME _____ M / F DOB: _____ AGE: _____
(LAST) (FIRST) (MI)

ADDRESS _____ HOME PHONE _____
(STREET) (CITY/TOWN) (ZIP)

FATHER _____ WORK PHONE _____ CELL PHONE _____

MOTHER _____ WORK PHONE _____ CELL PHONE _____

PARENT/GUARDIAN'S EMAIL ADDRESS _____

STUDENT RESIDES WITH ___ MOTHER & FATHER ___ MOTHER ___ FATHER ___ GUARDIAN

OTHER (PLEASE SPECIFY): _____ CUSTODY ARRANGEMENTS ___ YES ___ NO

IF UNABLE TO REACH PARENT IN CASE OF EMERGENCY, CONTACT:

(NAME) (ADDRESS) (PHONE #)

(NAME) (ADDRESS) (PHONE #)

FAMILY PHYSICIAN _____ PHONE # _____

SIGNIFICANT HEALTH PROBLEMS: Y N (circle one)

ALLERGIES _____

INSURANCE INFORMATION

INSURANCE COMPANY: _____

INSURANCE TYPE: HMO/PPO ETC. _____

ID# _____ GROUP # _____

I hereby give my permission that in the event of an emergency

(PRINT STUDENT'S NAME ABOVE)

MAY be taken to the hospital for treatment. The hospital may administer emergency medical treatment if necessary.

Signature _____ Date _____ / _____ / _____

NOTE: IN THE EVENT OF AN EMERGENCY, THE COACH AND ATHLETIC TRAINER WILL RELY ON THE ABOVE INFORMATION.

HOLY SPIRIT HIGH SCHOOL NJSIAA PARENT/GUARDIAN CONCUSSION POLICY ACKNOWLEDGMENT FORM

In order to help protect the student athletes of New Jersey, the NJSIAA has mandated that all athletes, parents/guardians and coaches follow the NJSIAA Concussion Policy.

A concussion is a brain injury and all brain injuries are serious. They may be 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/player 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:

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

Signs observed by teammates, parents and coaches include:

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

What can happen if my child/player keeps on playing with a concussion or returns too 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. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) 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 student-athlete's safety.

If you think your child/player 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. Close observation of the athlete should continue for several hours. An athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time and may not return to play until the athlete is evaluated by a medical doctor or doctor of Osteopathy, **trained in the evaluation and management of concussion and received written clearance to return to play from that health care provider**. You should also inform you child's Coach, Athletic Trainer (ATC), and/or Athletic Director, if you think that your child/player may have a concussion. And when it doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:

<http://www.cdc.gov/ConcussionInYouthSports/>
www.nfhslearn.com

Signature of Student-Athlete Print Student-Athlete's Name Date

Signature of Parent/Guardian Print Parent/Guardian's Name Date

Please keep this form on file at the school. Do not return to the NJSIAA. Thank you.

NJDOE/APPEF Revised 3/10 Use of this form is required by N.J.A.C. 6A:16-*Programs to Support Student Developmen*

HOLY SPIRIT HIGH SCHOOL
NJSIAA STEROID TESTING POLICY
CONSENT TO RANDOM TESTING

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

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

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

Signature of student-athlete

Date

Signature of parent/guardian

Date