

# 2022-2023

## 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 1<sup>st</sup> each year based on a physical performed by the signing physician within one year of the date of signature.**

### Key Changes:

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

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

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

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

For the physicals of 9<sup>th</sup> 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 _____

- 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:** \_\_\_\_\_

- 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:** \_\_\_\_\_

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

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

- 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:** \_\_\_\_\_

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

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

Name \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Sex \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

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

**\* See repeat responders versus first responders**

GENERAL QUESTIONS	Yes	No
1. Do you have any concerns you would like to discuss with your provider?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has a provider ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any medical issues or recent illness?	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOU:	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Has a doctor told you that you have any heart issues?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever requested a test for your heart? For example, electrocardiogram (EKG) or echocardiogram?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you get light headed or feel shorter of breath more than your friends during exercise ?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>
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 hycardia (CPVT)?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has anyone in your family had a pacemaker , or implanted defibrillator before age 35?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
MEDICAL QUESTIONS	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you been diagnosed with COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you have groin or, testicle pain or a painful bulge or hernia in the groin area?	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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

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

Signature of Athlete: \_\_\_\_\_ Date: \_\_\_\_\_ Signature Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

# 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 belt, 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 <input type="checkbox"/> Y <input type="checkbox"/> N
<b>MEDICAL</b>	<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>
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		
<b>MUSCULOSKELETAL</b>		
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

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

**HEALTHCARE PROFESSIONAL: THIS FORM [4] MUST BE USED IN CONJUNCTION WITH MEDICAL HISTORY FORM [3] AND MEDICAL CARD [5]. THIS FORM AND MEDICAL CARD MUST BE SIGNED BY MD/DO/NP/PA**

Comments:

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

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of HealthCare Professional: \_\_\_\_\_ Date of Clearance \_\_\_\_\_

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

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**SCHOOL ATHLETE MEDICAL CARD \***  
 (Parent/Guardian: Please complete Sections 1, 2 & 3. Please print.)

**Section 1: Contact /Personal Information**

Name: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
 Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Guardian Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: (H) \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_ (P) \_\_\_\_\_  
 Other Authorized Person To Contact In Case Of Emergency:  
 Name: \_\_\_\_\_ Phone(s): \_\_\_\_\_  
 Name: \_\_\_\_\_ Phone(s): \_\_\_\_\_  
 Preference Of Physician (And Permission To Contact If Needed): \_\_\_\_\_  
 Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Hospital Preference: \_\_\_\_\_ Insurance: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Group: \_\_\_\_\_ Phone: \_\_\_\_\_

**Section 2: Medical Information**

Medical Illnesses: \_\_\_\_\_  
 Last Tetanus (Mo/Yr): \_\_\_\_\_ Allergies: \_\_\_\_\_ Braces/Splints: \_\_\_\_\_  
 Medications: \_\_\_\_\_  
*(Any medication(s) that may need to be taken during competition require a physician's note.)*  
 Previous Head/Neck/Back Injury: \_\_\_\_\_  
 Heat Disorder, Or Sickle Cell Trait: \_\_\_\_\_  
 Previous Significant Injuries: \_\_\_\_\_  
 Any Other Important Medical Information: \_\_\_\_\_

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

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

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Athlete's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Section 4: Clearance for Participation**

\_\_\_\_ Not Cleared \_\_\_\_ Cleared without restrictions \_\_\_\_ Cleared with the following restrictions: \_\_\_\_\_  
 \_\_\_\_\_  
 Health Care Provider's Signature: \_\_\_\_\_ MD/DO, PA, NP Date: \_\_\_\_\_

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

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

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

**Name of School:** \_\_\_\_\_ **Name of School QHP:** \_\_\_\_\_



## 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/](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.***



## 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 (Comotio 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](http://www.heart.org))
- August Heart ([www.augustheart.org](http://www.augustheart.org))
- Championship Hearts Foundation ([www.champhearts.org](http://www.champhearts.org))
- Cody Stephens Foundation ([www.codystephensfoundation.org/](http://www.codystephensfoundation.org/))
- Parent Heart Watch ([www.parentheartwatch.com](http://www.parentheartwatch.com))
- NFHS Learn Center – Sudden Cardiac Arrest Video ([www.nfhslearn.com](http://www.nfhslearn.com))

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