Athlete _____ School Year _____

Sport(s) _____ Grade_____

Pius X High School Athletic Wellness, Medical, and Information Packet

- Must be completed and turned in prior to participating in the first day of practice/tryouts.
- Family should make a copy to keep for personal records.
- This packet can be emailed directly to jake.moore@piusx.net or turned in to the school or athletic office.

Concussion and Neurocognitive Baseline Testing Information

Athlete Name_____ Sport(s) _____Grade_____

Baseline Testing must be completed prior to the FIRST DAY OF PRACTICE.

Baseline Testing
Baseline Testing refers to neurocognitive testing under normal conditions before injury, typically conducted in the pre-season. The baseline test provides a snapshot of how one's brain functions in normal, everyday circumstances. Baseline testing is conducted on-site at schools by trained school staff with assistance from athletic trainers trained in concussion diagnosis, treatment, and care. It takes ~25 minutes to complete the baseline test. The testing application formulates "baseline data" which are stored on a secure, HIPPA compliant which can be retrieved anytime at a later date if an athlete sustains a concussion.

Post-Injury Testing
In the event an athlete sustains a concussion, the athlete is tested again post-injury. Post-injury testing composite scores are then compared to the baseline scores acquired earlier before a concussion injury affected brain function. Therefore, concussion baseline testing only becomes of value if, and when, post-testing is utilized after a concussion injury. An estimated 10% of athletes on average (~15%-20% of football players) in collision and contact sports will risk concussion injury necessitating post-injury testing.

Post-Injury Testing is conducted by medical or appropriate health care professionals having specialized training and credentialing to interpret and evaluate post-testing composite scores for deficiencies or abnormalities. These trained professionals will objectively base concussion management decisions and the decision for return to play on post-test comparisons, depending on when post-test scores return to baseline, among other clinical considerations. Hence, more consistent, objective, and safer decisions can then be made about an injured athlete returning to play. Subjectivity is far less apparent, and an athlete can potentially be allowed back sooner, rather than their return to play being delayed by uncertainty.

Post-Injury Testing is usually conducted once a concussed athlete is symptom-free (asymptomatic), or as early as 24-72 hrs. post-injury, depending on the healthcare provider managing the athlete's condition. When post-concussion testing is opted for online, another form of the test is selected having a different word and design lists, as well as other randomized stimuli. On occasion, multiple post-tests (serial testing) may be conducted to monitor an athlete's recovery over time.

If post-testing scores have not recovered in sufficient time, (usually within 3-4 weeks) the athlete may be referred to a neuro-specialist with advanced, formal training in treating head injuries, i.e. Neurosurgeon, Neuropsychologist, or Neurologist.

Testing Cycle
Baseline testing will be available for 9th through 12th grade athletes participating in collision and contact sports having the highest incidence of concussions [football, volleyball, basketball, wrestling, diving, soccer, track-jumpers, baseball, and softball]. An athlete's baseline is acquired on a 2-year cycle, with testing of incoming 9th graders and 11th grade each year. Anyone new to an athletic program or having sustained a concussion the previous year is tested each year as well.

Concussion Information
All Parents and Athletes should review signs and symptoms of Concussions.
Signs and symptoms of a concussion may include:

Headache or a feeling of pressure in the head	Temporary loss of consciousness	Confusion or feeling as if in a fog
Amnesia surrounding the traumatic event	Dizziness or "seeing stars"	Ringing in the ears
Nausea	Vomiting	Slurred speech
Delayed response to questions	Appearing dazed	Fatigue

You may have some symptoms of concussions immediately. Others may be delayed for hours or days after injury, such as:

Concentration and memory complaints	Irritability and other personality changes	Sensitivity to light and noise
Psychological adjustment problems and depression	Sleep disturbances	Disorders of taste and smell

Signs and Symptoms, along with other notable injury information can be viewed on the following website:
https://www.piusx.net/athletics/trainers/

We have reviewed and understand the Concussion Testing information. We have also reviewed and understand the signs and symptoms of Concussions.

Athlete Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

Assumption of Risk

Athlete Name_____ Sport(s) _____Grade_____

Part I: Assumption of Risk, Release and Waiver of Liability, and Indemnity
In consideration of being permitted in Athletics at Pius X High School, I, the undersigned, hereby agree as follows:

We hereby acknowledge and agree that we understand the nature of Athletics that I will be participating in at Pius X; we are aware that there are certain risks and dangers associated with participating in athletics at Pius X, including risks of illness, injury, and death; and we knowingly and voluntarily accept and assume responsibility for such risks and dangers that could arise out of, or occur during, my participation in athletics, even if such risks and dangers arise in whole or in part from negligence of Pius X and/or its employees, agents, and representatives.

We hereby warrant that I am qualified, in good health, and in proper physical condition to participate in athletics at Pius X. I hereby release and forever discharge Pius X and its past, present, and future officers, directors, partners, shareholders, members, managers, agents, employees, successors, subsidiaries, parents, assigns, representatives, attorneys, affiliates, heirs and insurers, from any and all liability, loss, damages, costs, claims and/or causes of actions resulting from any accident, illness, bodily harm, personal injury, death, and/or property loss, however caused from or in any way related to my participation in athletics at Pius X, including losses caused in whole or in part by the negligence of Pius X and/or its employees, agents, and representatives. Further, and to the same extent and scope, I release said parties from any claim whatsoever that may be attributable to the receipt of first aid or other medical treatment rendered to me in connection with my participation in athletics at Pius X High School.

We hereby agree to indemnify and hold harmless Pius X High school and its past, present, and future officers, director, partners, shareholders, members, managers, agents, employees, successors, subsidiaries, parents, assigns, representatives, attorneys, affiliates, heirs and insurers, from any and all claims, demands, lawsuits, liabilities, damages, expenses (including reasonable attorney fees), and/or costs arising out of or related to my participation in athletics at Pius X High School.

We have read this Assumption of Risk, Release and Waiver of Liability, and Indemnity Agreement in its entirety and understand and agree to its terms.

Athlete Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

Medical Consent to Treat

Part II Medical Consent

We authorize Pius X High School designated Certified Athletic Trainers and/or medical personnel to provide me with any preventative, first-aid, rehabilitative or emergency treatment deemed necessary to my health and well-being as a result of injuries or other medical conditions occurring as the result of or during Pius X High School athletic activities. I give permission for medical information to be released and discussed with the certified athletic training staff, school nurse, team coaches, and strength coaches, athletic administrators, faculty representatives, parents and/or guardians. If reasonably necessary to provide the care described in the preceding paragraphs, I grant permission to Pius X High School official to authorize my admission to a hospital or facility that provides said treatment.

I have read this medical consent in its entirety and understand and agree to its terms.

I understand that I have the right to revoke all or any part or the above at any time by sending a written notification to Pius X High School Athletic Director. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization/consent. I have read and fully understand the Pius X High School athletic program requirements and all information supplied is accurate and current to the best of my knowledge.

Athlete Signature_____ Date_____

Parent/Guardian Signature_____ Date_____

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	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

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that 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 ongoing 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 ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath 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 an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
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)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that 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	**Yes**	**No**
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 past 12 months?		

Explain "Yes" answers here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

■ PREPARTICIPATION PHYSICAL EVALUATION

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: _____ Date of birth: _____

1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	Yes	**No**
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "Yes" answers here.

_____

_____

_____

Please indicate whether you have ever had any of the following conditions:

	Yes	**No**
Atlantoaxial instability		
Radiographic (x-ray) evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "Yes" answers here.

_____

_____

_____

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-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: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
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 electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a comination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

I hereby give permission for the release of the attached student medical history and the results of the actual physical examination to the school for the purposes of participation in athletics and activities.

Parent or Legal Guardian Signature _____ *Date* _____

PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____