

**Fayette Academy  
Sports Medical Form**

**Must be completed and returned BEFORE any sports participation**

**I. Physician's Certificate**

I hereby certify that (name) \_\_\_\_\_ has been examined by me and found physically fit to engage in all school athletics.

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
Date: \_\_\_\_\_ Physician's Signature \_\_\_\_\_

**II. Emergency Treatment**

To All Parents:

Since the malpractice question has come to the forefront, many hospitals and doctors will not treat a child without a parent's consent (unless a matter of life or death). It is requested that you complete the information below so that if your child requires a visit to the hospital while under the supervision of the school, this will allow the hospital to treat the injury.

Emergency Information

Name \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_  
Grade \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Parent's Name \_\_\_\_\_  
Home Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Father's cell \_\_\_\_\_ Mother's cell \_\_\_\_\_  
Another Person to Contact \_\_\_\_\_  
Relationship \_\_\_\_\_ Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_  
Group Name \_\_\_\_\_ Group Number \_\_\_\_\_  
ALLERGIES \_\_\_\_\_  
MEDICATIONS \_\_\_\_\_

**III. Parent's Consent for Athletic Participation**

I hereby give my consent for (student's name) \_\_\_\_\_

TO REPRESENT FAYETTE ACADEMY IN THE FOLLOW SPORTS:

\_\_\_\_\_  
\_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

**IV. Parent's Consent Statement: Authorizing Treatment**

I/We hereby give consent for (athlete's name) \_\_\_\_\_ to represent Fayette Academy in athletics realizing that such activity involves potential for injury. I/We acknowledge that even with the best coaching, the most advanced equipment, and strict observation of the rules, injuries are still possible. On rare occasions these injuries are severe and result in disability, paralysis, and even death. I/We grant permission to the school and TSSAA, its physicians, athletic trainers, and /or EMT to render aid, treatment, medical, or surgical care deemed reasonably necessary to the health and well-being of the student athlete named above during or resulting from participation in athletics. By the execution of this consent, the student athlete named above, and his/her parent/guardian(s) do hereby consent to screening, examination, and testing of the student athlete during the course of the pre-participation examination by those performing the evaluation, and to the taking of medical history information and the recording of that history and the findings and comments pertaining to the student athlete on the forms attached hereto by those practitioners performing the examination. As parent or legal Guardian, I/We remain fully responsible for any legal responsibility which may result from any personal actions taken by the above-named student athlete.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Student-Athlete Authorization  
For  
Disclosure of Protected Health Information**

I hereby authorize the physicians, athletic trainers, physical therapists and sports medicine personnel representing Campbell Clinic to disclose protected health information regarding any injury or illness affecting the student-athlete's training for and participation in athletics at **Fayette Academy**. Campbell Clinic is authorized to disclose this protected health information to any coach, the athletic director, or any school official in connection with his/her participation in interscholastic sports. This protected health information may concern the student-athlete's medical status, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected health information may be disclosed to other health care providers within the Campbell Clinic system; to **Fayette Academy** Administrators; and to officials of the Tennessee Secondary School Athletic Association.

I, \_\_\_\_\_, parent or guardian of

\_\_\_\_\_,  
(name of parent/guardian)

\_\_\_\_\_  
(name of student)

understand that parent/legal guardian authorization/consent for the disclosure of the student-athlete's protected health information is a condition for participation as an interscholastic athlete at **Fayette Academy** and for care during interscholastic athletics. I understand that my child's protected health information is protected by the federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment). This protected health information may not be disclosed without parent/legal guardian authorization under HIPAA or consent under the Buckley Amendment. I, the parent/legal guardian, understand that once information is disclosed per authorization or consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or the Buckley Amendment. I, the parent/legal guardian, understand that I may revoke this authorization/consent at any time by notifying in writing Campbell Clinic. If authorization or consent is revoked, it will not have any effect on the actions Campbell Clinic personnel took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent is enacted on the date of signature and expires on May 31, 2022. Campbell Clinic will not condition your treatment on the signing of an authorization, except for any possible research-related treatment.

REQUIRED SIGNATURE FOR PARTICIPATION FOR INTERSCHOLASTIC SPORTS

\_\_\_\_\_  
Print Student-Athlete's Name

\_\_\_\_\_  
Signature of Parent/Legal Guardian

# CONCUSSION

## INFORMATION AND SIGNATURE FORM FOR STUDENT-ATHLETES & PARENTS/LEGAL GUARDIANS (Adapted from CDC "Heads Up Concussion in Youth Sports")

Public Chapter 148, effective January 1, 2014, requires that school and community organizations sponsoring youth athletic activities establish guidelines to inform and educate coaches, youth athletes and other adults involved in youth athletics about the nature, risk and symptoms of concussion/head injury.

**Read and keep this page.**

**Sign and return the signature page.**

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow or jolt to the head or body that causes the head and brain to move rapidly back and forth. Even a "ding," "getting your bell rung" or what seems to be a mild bump or blow to the head can be serious.

### Did You Know?

- Most concussions occur *without* loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

### WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports **one or more** symptoms of concussion listed below after a bump, blow or jolt to the head or body, s/he should be kept out of play the day of the injury and until a health care provider\* says s/he is symptom-free and it's OK to return to play.

SIGNS OBSERVED BY COACHING STAFF	SYMPTOMS REPORTED BY ATHLETES
Appears dazed or stunned	Headache or "pressure" in head
Is confused about assignment or position	Nausea or vomiting
Forgets an instruction	Balance problems or dizziness
Is unsure of game, score or opponent	Double or blurry vision
Moves clumsily	Sensitivity to light
Answers questions slowly	Sensitivity to noise
Loses consciousness, even briefly	Feeling sluggish, hazy, foggy or groggy
Shows mood, behavior or personality changes	Concentration or memory problems
Can't recall events <i>prior</i> to hit or fall	Confusion
Can't recall events <i>after</i> hit or fall	Just not "feeling right" or "feeling down"

\*Health care provider means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training

## CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention after a bump, blow or jolt to the head or body if s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that not only does not diminish, but gets worse
- Weakness, numbness or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless or agitated
- Has unusual behavior
- Loses consciousness (*even a brief loss of consciousness should be taken seriously*)

## WHY SHOULD AN ATHLETE REPORT HIS OR HER SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brains. *They can even be fatal.*

### Remember:

Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

## WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care provider\* says s/he is symptom-free and it's OK to return to play.

Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration such as studying, working on the computer or playing video games may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

\* Health care provider means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training.

## Student-athlete & Parent/Legal Guardian Concussion Statement

Must be **signed and returned** to school or community youth athletic activity prior to participation in practice or play.

Student-Athlete Name: \_\_\_\_\_

Parent/Legal Guardian Name(s): \_\_\_\_\_

After reading the information sheet, I am aware of the following information:

Student-Athlete initials		Parent/Legal Guardian initials
	A concussion is a brain injury which should be reported to my parents, my coach(es) or a medical professional if one is available.	
	A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.	
	I will tell my parents, my coach and/or a medical professional about my injuries and illnesses.	N/A
	I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.	N/A
	I will/my child will need written permission from a <i>health care provider</i> * to return to play or practice after a concussion.	
	Most concussions take days or weeks to get better. A more serious concussion can last for months or longer.	
	After a bump, blow or jolt to the head or body an athlete should receive immediate medical attention if there are any danger signs such as loss of consciousness, repeated vomiting or a headache that gets worse.	
	After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before the concussion symptoms go away.	
	Sometimes repeat concussion can cause serious and long-lasting problems and even death.	
	I have read the concussion symptoms on the Concussion Information Sheet.	

\* *Health care provider* means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal guardian

\_\_\_\_\_  
Date

## **Athlete/Parent/Guardian Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form**

### **What is sudden cardiac arrest?**

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens, blood stops flowing to the brain and other vital organs. SCA doesn't just happen to adults; it takes the lives of students, too. However, the causes of sudden cardiac arrest in students and adults can be different. A youth athlete's SCA will likely result from an inherited condition, while an adult's SCA may be caused by either inherited or lifestyle issues. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

### **How common is sudden cardiac arrest in the United States?**

SCA is the #1 cause of death for adults in this country. There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year. It is the #1 cause of death for student athletes.

### **Are there warning signs?**

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

- fainting or seizures during exercise;
- unexplained shortness of breath;
- dizziness;
- extreme fatigue;
- chest pains; or
- racing heart.

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

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

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

### **Public Chapter 325 – the Sudden Cardiac Arrest Prevention Act**

The act is intended to keep youth athletes safe while practicing or playing. The requirements of the act are:

- All youth athletes and their parents or guardians must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.

- The immediate removal of any youth athlete who passes out or faints while participating in an athletic activity, or who exhibits any of the following symptoms:
  - (i) Unexplained shortness of breath;
  - (ii) Chest pains;
  - (iii) Dizziness
  - (iv) Racing heart rate; or
  - (v) Extreme fatigue; and
- Establish as policy that a youth athlete who has been removed from play shall not return to the practice or competition during which the youth athlete experienced symptoms consistent with sudden cardiac arrest
- Before returning to practice or play in an athletic activity, the athlete must be evaluated by a Tennessee licensed medical doctor or an osteopathic physician. Clearance to full or graduated return to practice or play must be in writing.

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

---

Signature of Student-Athlete

Print Student-Athlete's Name Date

---

Signature of Parent/Guardian

---

Print Parent/Guardian's Name Date