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:

- 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 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 the first day of Fall practice 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 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:**_____

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 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?		
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 hycardia (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 *Staphlocccus 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 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 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 Staphlococcus 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 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_____

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 (if over 18 yo): _____ **Date**: _____

Section 4: Clearance for Participation

_____Not Cleared _____Cleared without restrictions _____Cleared with the following restrictions: _____

_____

Qualified Health Care Provider's Signature: _____ MD/DO, PA, NP, School Nurse, ATC

Date: _____

***For School Office Use Only**: This card is valid from April 1, 20 _____ through First day of Fall practice 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 Form

A concussion is a traumatic brain injury that is caused by a forceful blow to the head, neck, or body that results in a transmitted force to the head/brain. The injury occurs at a cellular level resulting in the signs and symptoms observed with a concussion. Because the injury occurs at a cellular level, imaging studies including MRIs and CT scans will not detect a concussion. Signs and symptoms of a concussion usually start immediately after the injury but can start hours or days after the injury. Most concussions occur without loss of consciousness. If there are any concerns that your child may have a concussion, please refrain them from all sports and seek medical attention immediately.

The athlete may experience one or more of the following symptoms:

Headaches	Pressure in head	Neck pain	Nausea or vomiting	Dizziness	Blurred vision	Balance problems
Sensitivity to light or noise	Feeling slowed down	Feeling foggy	"Don't feel right"	Difficulty concentrating	Difficulty remembering	Fatigue or low energy
Confusion	Drowsiness	More emotional	Irritability	Sadness	Nervous or anxious	Changes in sleep

Parents, teammates, coaches may observe one or more of the following:

Can't recall events prior to or after a hit or fall	Appears dazed or stunned	Forgetful of instructions, assignments or position	Forgetful of game, score, or opponent
Answers questions slowly	Loss of consciousness (can be brief)	Mood, behavior, or personality changes	Moves clumsily, off balance

What can happen if my child keeps on playing with a concussion or returns too soon? What do I do if I think my child has suffered a concussion?

Athletes showing signs and symptoms concerning for a concussion should be removed from play immediately and be assessed by a qualified healthcare provider. An athlete is at increased risk for more severe concussion symptoms and prolonged recovery if they sustain another head injury prior to recovery from the initial concussion. An athlete playing with a concussion is also at risk for musculoskeletal injuries due to delayed reaction time and balance issues. Athletes may under report concussion symptoms so it is important that observers are watchful during sporting events. As a result, education of administrators, coaches, parents, and students is key for the student-athlete's safety. Repetitive concussions may increase risk for chronic traumatic encephalopathy and traumatic encephalopathy syndrome but more research is needed to establish a clear association. If you are not sure if your child has a concussion, keep them out from sports until evaluated by a qualified healthcare provider.

For current and up-to-date information from the CDC on concussions, you can go to:
https://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/
For a free online video on concussions, you can go to:
https://nfhslearn.com/courses/concussion-in-sports-2

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

Adapted from the CDC and 6th International Conference on Concussion in Sport, 3/2024

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.