Thanks for scheduling your child's Sports Physical with Grace Clinics of Ohio.

Please arrive 5 minutes prior to your appointment to get checked in! Bring the following paperwork completed with you to your appointment.

- Grace Clinic Patient Information Form (Page 1)
- OHSAA Sports Physical **HISTORY FORM** (Page 2 & 3)
    - Note: Only complete page 4 if it applies to your student
    - Pages 5 & 6 (Medical Exam & Eligibility Form) will be completed by the provider during the Sports Physical.

We will confirm your appointment the week before. If we do not hear back from you to confirm, your appointment may be given to another patient.

Blessings,

Grace Clinics of Ohio Team

PATIENT LABEL

Date: _____

PATIENT INFORMATION

First Name			Last Name
DOB	MM / DD / YYYY	Sex ◯ Female ◯ Male	Phone
Address			County
City			State / Zip

Marital Status ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

Language ◯ English ◯ Spanish ◯ Portuguese ◯ Haitian Creole ◯ Ukrainian ◯ Other

Race ◯ Asian ◯ Pacific Islander ◯ Black ◯ African ◯ Native American ◯ White ◯ European ◯ Multiracial

Ethnicity ◯ Hispanic / Latino ◯ Not Hispanic / Latino

Do you meet Grace Clinic income guidelines? ◯ Yes ◯ No **Do you have insurance?** ◯ No ◯ Medicaid ◯ Other

Do you want to pray with our prayer team during your visit? ◯ Yes ◯ No **Religious Preference?**

GUARDIAN INFORMATION - If patient is under the age of 18, please complete the information below

Parent Guardian Name DOB Relationship ◯ Parent ◯ Guardian

RELEASE OF INFORMATION & CONSENT FOR TREATMENT

I, _____ hereby give Grace Clinic of Ohio permission to release health records and/or give verbal information about my health to any and all healthcare providers from whom I may seek additional care or treatment arising from and reasonably related to the services provided by Grace Clinics of Ohio. I also give any and all healthcare providers from whom I may seek additional care or treatment from and reasonably related to the services provided by Grace Clinics of Ohio, permission to obtain copies of health records and/or to receive verbal information about my health. I understand that the information released and/or obtained will be used only for the purposes of providing care at Grace Clinics of Ohio or for other reasons only after a release has been signed for that particular purpose.

I _____ hereby consent to the provision of care, diagnosis and/or treatment by the Grace Clinics of Ohio and I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing. I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the care, diagnosis and/or treatment and am not subject to duress or under undue influence.

REVIEW OF PATIENT RIGHTS & RESPONSIBILITIES

_____ I have read and I understand the Patient Rights & Responsibilities as posted in Grace Clinics of Ohio. I have had the opportunity to ask questions or request explanation from a volunteer and/or staff member.

_____ I have read and I understand the notice of Limited Liability for Free Clinic Volunteer Health Care Professionals, Board Members, Officers, Employees, and Independent Contractors as posted in Grace Clinic of Ohio. Being mentally competent and under no duress or undue influence, I am giving informed consent to the qualified immunity that extends to health care providers of Grace Clinics of Ohio, Inc. who provide diagnosis, care, or treatment as long as no compensation is received or expected and is provided in a free clinic.

_____ I have read and I understand the Telemedicine Consent Form, and authorize Grace Clinic of Ohio to allow me/the patient to participate in a telemedicine (video conferencing service)

_____ I authorize Grace Clinics of Ohio to use my photos/videos for promotional materials, advertisements, social media, and other communications, without payment. This permission applies to all formats and markets, now and in the future, and continues indefinitely unless I revoke it in writing. I understand these materials will become the property of Grace Clinics of Ohio and will not be returned. I release Grace Clinics of Ohio from all liability related to the use of these materials

_____ All care and services provided in-house at Grace Clinics are always free of charge. If your provider orders testing that must be sent to an outside laboratory or facility, you may receive a bill from that organization.

PREPARTICIPATION PHYSICAL EVALUATION | OHIO HIGH SCHOOL ATHLETIC ASSOCIATION | 2026-27

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, non-binary, or another gender): _____

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	Unsure	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 cardio-myopathy (HCM), Marfan syndrome, arrhyth-mogenic 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, 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? **Unsure**		
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?		

MENSTRUAL QUESTIONS	N/A	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: _____

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 | 2026-27

PHYSICAL EXAMINATION FORM

Name: _____ Date of Birth: _____ Year of Graduation: _____

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		

[a] *Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.*

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

Address: _____ Phone: _____

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

PREPARTICIPATION PHYSICAL EVALUATION | OHIO HIGH SCHOOL ATHLETIC ASSOCIATION | 2026-27

MEDICAL ELIGIBILITY FORM

Name: _____ Date of Birth: _____ Year of Graduation: _____

☐ 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 is 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 of Exam: _____

Address: _____ Phone: _____

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

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

PREPARTICIPATION PHYSICAL EVALUATION | 2026 – 2027

THE STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE SCHOOL

OHSAA AUTHORIZATION FORM | 2026 – 2027

I hereby authorize the release and disclosure of the personal health information of _____ ("Student"), as described below, to _____ ("School").

The information described below may be released to the School principal or assistant principal, athletic director, coach, athletic trainer, physical education teacher, school nurse or other member of the School's administrative staff as necessary to evaluate the Student's eligibility to participate in school sponsored activities, including but not limited to interscholastic sports programs, physical education classes or other classroom activities.

Personal health information of the Student which may be released and disclosed includes records of physical examinations performed to determine the Student's eligibility to participate in school sponsored activities, including but not limited to the Pre-participation Evaluation form or other similar document required by the School prior to determining eligibility of the Student to participate in classroom or other School sponsored activities; records of the evaluation, diagnosis and treatment of injuries which the Student incurred while engaging in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in school sponsored activities.

The personal health information described above may be released or disclosed to the School by the Student's personal physician or physicians; a physician or other health care professional retained by the School to perform physical examinations to determine the Student's eligibility to participate in certain school sponsored activities or to provide treatment to students injured while participating in such activities, whether or not such physicians or other health care professionals are paid for their services or volunteer their time to the School; or any other EMT, hospital, physician or other health care professional who evaluates, diagnoses or treats an injury or other condition incurred by the student while participating in school sponsored activities.

I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored and classroom activities, and that the School is a not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the School is covered under the federal regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.

I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student's participation in certain school sponsored activities may be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to the school principal (or designee) whose name and address appears below.

Name of Principal: _____

School Address: _____

This authorization will expire when the student is no longer enrolled as a student at the school.

NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS AUTHORIZATION PERSONALLY.

_____

Student's Signature — Birth date of Student, including year

_____

Name of Student's personal representative, if applicable

I am the Student's (check one): _____ Parent _____ Legal Guardian (documentation must be provided)

_____

Signature of Student's personal representative, if applicable — Date

A copy of this signed form has been provided to the student or his/her personal representative

PREPARTICIPATION PHYSICAL EVALUATION | 2026 – 2027

2026-2027 Ohio High School Athletic Association Eligibility and Authorization Statement

This document is to be signed by the participant from an OHSAA member school and by the participant's guardian

I have read, understand and acknowledge receipt of the **OHSAA Student Eligibility Guide and Checklist** (https://ohsaaweb.blob.core.windows.net/files/Eligibility/OtherEligibiltyDocs/EligibilityGuideHS.pdf) which contains a summary of the eligibility rules of the Ohio High School Athletic Association. I understand that a copy of the *OHSAA Handbook* is on file with the principal and athletic administrator and that I may review it, in its entirety, if I so choose. All OHSAA bylaws and regulations from the *Handbook* are also posted on the OHSAA website at ohsaa.org.
I understand that an OHSAA member school must **adhere to all rules and regulations** that pertain to the interscholastic athletics programs that the school sponsors, but that local rules may be more stringent than OHSAA rules.
I understand that participation in interscholastic athletics is a **privilege not a right**.

Student Code of Responsibility

As a student athlete, I **understand and accept** the following responsibilities:

- I will **respect the rights and beliefs** of others and will treat others with courtesy and consideration.
- I will be **fully responsible** for my own actions and the consequences of my actions.
- I will **respect the property** of others.
- I will **respect and obey the rules** of my school and laws of my community, state and country.
- I will **show respect to those who are responsible for enforcing the rules** of my school and the laws of my community, state and country.
- I **understand that a student whose character or conduct violates** the school's Athletic Code or School Code of Responsibility is not in good standing and is ineligible for a period as determined by the principal.

Informed Consent – By its nature, participation in interscholastic athletics includes risk of injury and transmission of infectious disease such as HIV and Hepatitis B. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants have a responsibility to help reduce that risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, GUARDIANS OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN AN OHSAA-SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN'S SIGNATURE.**

- I understand that in the case of **injury or illness requiring treatment by medical personnel and transportation to a health care facility**, that a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be treated and transported via ambulance to the nearest hospital.
- I **consent to medical treatment** for the student following an injury or illness suffered during practice and/or a contest.
- To enable the OHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics in an OHSAA member school, I **consent to the release to the OHSAA any and all portions of school record files**, beginning with seventh grade, of the herein named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s)or guardian(s), enrollment documents, financial and scholarship records, residence address of the student, academic work completed, grades received and attendance data.
- I **consent to the OHSAA's use of the herein named student's name**, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.
- I **understand that if I drop a class**, take course work through College Credit Plus, Credit Flexibility or other educational options, this action could affect compliance with OHSAA academic standards and my eligibility. **I accept full responsibility** for compliance with Bylaw 4-4, Scholarship, and the passing five credit standard expressed therein.
- I **understand all concussions are potentially serious** and may result in complications including prolonged brain damage and death if not recognized and managed properly. Further I understand that if my student is removed from a practice or competition due to a suspected concussion, he or she will be unable to return to participation that day. After that day written authorization from a physician (M.D. or D.O.) or another health care provider working under the supervision of a physician will be required in order for the student to return to participation.
- I **have read and signed** the Ohio Department of Health's **Concussion Information Sheet** and have retained a copy for myself.
- I **have read and signed** the Ohio Department of Health's **Sudden Cardiac Arrest Information Sheet** and have retained a copy for myself.

By signing this we acknowledge that we have read the above information and that we consent to the herein named student's participation.

***Must Be Signed Before Physical Examination**

_____

Student's Signature | Birth Date | Year of Graduation | Date

_____

Parent's or Guardian's Signature | Date

Department of Health

Department of Health
Ohio Injury Prevention Partnership
Child Injury Action Group

Ohio Department of Health Concussion Information Sheet: *For Interscholastic Athletics*

Dear Parent/Guardian and Athletes,

This information sheet is provided to assist you and your child in recognizing the signs and symptoms of a concussion. Every athlete is different and responds to a brain injury differently, so seek medical attention if you suspect your child has a concussion. Once a concussion occurs, it is very important your athlete returns to normal activities slowly, so they do not do more damage to their brain.

What is a Concussion?[1]

According to the Center for Disease Control and Prevention (CDC) a concussion is a type of traumatic brain injury-or TBI-caused by a bump, blow, or jolt to the head or by a hit to the body that cause the head and brain to move quickly back and forth. This fast movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging the brain cells.

Signs and Symptoms of a Concussion[1]

Signs and symptoms generally show up soon after the injury. However, you may not know how serious the injury is at first and some symptoms may not show up for hours or days. For example, in the first few minutes your child or teen might have a headache or feel confused or a bit dazed. But a few days later, your child might have more trouble sleeping or changes in mood than usual.

You should continue to check for signs of concussion right after the injury and a few days after the injury. If your child or teen's concussion signs or symptoms get worse be sure to share this information with their healthcare provider.

Signs Observed by Parents or Guardians[1]

- Appears dazed or stunned.
- Is confused about assignment or position.
- Forgets instruction, is confused about an assignment or position, or is unsure of the game, score or opponent.
- Moves clumsily.
- Answers questions slowly.
- Loses consciousness *(even briefly)*.
- Shows mood, behavior, or personality changes.
- Can't recall events before or after hit or fall.

Symptoms Reported by Athlete[1]

- Headache or "pressure" in head.
- Nausea or vomiting.
- Balance problems or dizziness, or double or blurry vision.
- Bothered by light or noise.
- Feeling sluggish, hazy, foggy or groggy.
- Confusion, or concentration or memory problems.
- Just not "feeling right," or "feeling down".

Dangerous Signs & Symptoms of a Concussion [1]

- One pupil larger than the other.
- Drowsiness or inability to wake up.

- A headache that gets worse and does not go away.
- Slurred speech, weakness, numbness, or decreased coordination.
- Repeated vomiting or nausea, convulsions or seizures (shaking or twitching).
- Unusual behavior, increased confusion, restlessness, or agitation.
- Loss of consciousness (passed out/knocked out). Even a brief loss of consciousness should be taken seriously.

Be Honest

Encourage your athlete to be honest with you, their coach, and your health care provider about their symptoms. Many young athletes get caught up in the moment and/or feel pressured to return to sports before they are ready. It is better to miss one game than the entire season… or risk permanent damage!

Seek Medical Attention Right Away

Seeking medical attention is an important first step if you suspect or are told your child has a concussion. A qualified health care professional will be able to determine how serious the concussion is and when it is safe for your child to return to sports and other daily activities.

- No athlete should return to activity on the same day they get a concussion.
- Athletes should **NEVER** return to practices/games if they still have ANY symptoms.
- Parents and coaches should never pressure any athlete to return to play.

The Dangers of Returning Too Soon

Returning to play too early may cause Second Impact Syndrome (SIS) or Post-Concussion Syndrome (PCS). SIS occurs when a second blow to the head happens before an athlete has completely recovered from a concussion. This second impact causes the brain to swell, possibly resulting in brain damage, paralysis, and even death. PCS can occur after a second impact. PCS can result in permanent, long- term concussion symptoms. The risk of SIS and PCS is the reason why no athlete should be allowed to participate in any physical activity before they are cleared by a qualified health care professional.

Recovery

A concussion can affect school, work, and sports. Along with coaches and teachers, the school nurse, athletic trainer, employer, and other school administrators should be aware of the athlete's injury and their roles in helping the child recover.

During the recovery time after a concussion, physical and mental rest are required. A concussion upsets the way the brain normally works and causes it to work longer and harder to complete even simple tasks. Activities that require concentration and focus may make symptoms worse and cause the brain to heal slower. Studies show that children's brains take several weeks to heal following a concussion.

Returning to Daily Activities

1. Be sure your child gets plenty of rest and enough sleep at night – no late nights. Keep the same bedtime weekdays and weekends.
2. Encourage daytime naps or rest breaks when your child feels tired or worn-out.
3. Limit your child's activities that require a lot of thinking or concentration (including social activities, homework, video games, texting, computer, tablet, driving, job related activities, movies, parties). These activities can slow the brain's recovery.
4. Limit your child's physical activity, especially those activities where another injury or blow to the head may occur.
5. Have your qualified health care professional check your child's symptoms at different times to help guide recovery.

Department of Health

Department of Health
Ohio Injury Prevention Partnership
Child Injury Action Group

Returning to Learn (School)[1,2]

1. Following an initial period of relative rest (24-48 hours following an injury, athletes can begin a gradual and incremental increase in their cognitive load. Progression through the strategy for students should be slowed when there is more than a mild and brief symptom exacerbation. *Mild and brief exacerbation of symptoms is defined as an increase of no more than 2 points on a 0–10-point scale (with 0 representing no symptoms and 10 the worst symptoms imaginable) for less than an hour when compared to symptoms reported prior to cognitive activity.

2. Inform teacher(s), school counselor, school nurse, or administrator(s) about the injury and symptoms. School personnel should be instructed to watch for:

   a. *Increased problems paying attention.*

   b. *Increased problems remembering or learning new information.*

   c. *Longer time needed to complete tasks or assignments.*

   d. *Difficulty organizing tasks or shifting between tasks.*

   e. *Inappropriate or impulsive behavior during class.*

   f. *Greater irritability.*

   g. *Less ability to cope with stress.*

   h. *More emotional than usual.*

   i. *Fatigue.*

   j. *Difficulties handling a stimulating school environment (lights, noise, etc.).*

   k. *Physical symptoms (headache, nausea, dizziness).*

A return to learn (RTL) strategy is listed below. Not all athletes will need a return to learn strategy or academic support.

Returning to Learn (School) Strategies[1,2]

1.FIRST STEP: Daily activities can be incorporated that do not result in more than a *mild exacerbation of symptoms related to the current concussion. These include typical activities during the day (e.g., reading) while minimizing screen time. Start with 5-15 minutes at a time and increase gradually.

2.SECOND STEP: School activities can be incorporated which include homework, reading or other cognitive activities outside of the classroom. Some school activities can be incorporated such as homework, reading or other cognitive activities outside of the classroom.

3.THIRD STEP: Return to school part time with gradual introduction of schoolwork. May need to start with a partial school day or with greater access to rest breaks during the day.

4.FOURTH STEP: Return to school full time and gradually progress in school activities until a full day can be tolerated without more than *mild symptom exacerbation.

If your child is still having concussion symptoms, they may need extra help with school related activities. As the symptoms decrease during recovery, the extra help or supports can be removed gradually.

For more information, please refer to return to learn at the ODH website.

Returning to Play[1,2]

1. Returning to play is specific for each person, depending on the sport. **Starting 4/26/13, Ohio law requires written permission from a health care provider before an athlete can return to play.** Follow instructions and guidance provided by a health care professional. It is important that you, your child, and your child's coach follow these instructions carefully.

2. Your child should **NEVER** return to play if they still have **ANY** symptoms. (Be sure that your child does not have any symptoms at rest and while doing any physical activity and/or activities that require a lot of thinking or concentration).

3. Ohio law prohibits your child from returning to a game or practice on the same day they were removed.

4. Be sure that the athletic trainer, coach and physical education teacher are aware of your child's injury and symptoms.

5. Your athlete should complete a step-by-step exercise-based progression, under the direction of a qualified healthcare professional.

6. A sample activity progression is listed below. Each step typically takes a minimum of 24 hours. It is important for an athlete's parent(s) and coach(es) to watch for concussion symptoms after each day's return to sports progression activity. An athlete should only move to the next step if they do not have any new symptoms at the current step. If an athlete's symptoms come back or if he or she gets new symptoms, this is a sign that the athlete is pushing too hard. The athlete should stop these activities and the athlete's medical provider should be contacted. After more rest and no concussion symptoms, the athlete can start at the previous step.

Sample Activity Progression[1] [2]

1.FIRST STEP: Back to regular activities-The athlete is back to their regular activities (such as school) and has the green-light from their healthcare provider to begin the return to sports progression.

2.SECOND STEP: Light aerobic activity- Begin with light aerobic exercise only to increase an athlete's heart rate. This means about 5 to 10 minutes on an exercise bike, walking, or light jogging. No weightlifting at this point.

3.THIRD STEP: Moderate Activity/Individual Sport-Specific Exercise (if sport-specific training involves any risk of inadvertent head impact, medical clearance should occur prior to Step 3- Continue with activities to increase an athlete's heart rate with body or head movement. Sport -specific training away from the team environment. This includes change of direction and/or individual training drills away from the team environment, moderate jogging, brief running, moderate-intensity stationary biking, moderate-intensity weightlifting (less time and/or less weight from their typical routine). No activities at risk of head impact.

4.FOURTH STEP: Heavy, non-contact activity- Add heavy non-contact physical activity, such as sprinting/running, high-intensity stationary biking, regular weightlifting routine, non-contact sport-specific drills (in 3 planes of movement) integrated into a team environment.

5.FIFTH STEP: Practice & full contact- Athlete may return to practice and full contact (if appropriate for the sport) in controlled practice.

6.SIXTH STEP: Competition- Athlete may return to competition.

**Steps 4-6 should begin after the resolution of any symptoms, abnormalities in cognitive function and any other clinical findings related to the current concussion, including with and after physical exertion.*

Resources

[1]**Centers for Disease Control and Prevention**
https://www.cdc.gov/headsup/youthsports/

[2]**Consensus Statement Concussion in Sport**
Consensus Statement Concussion in Sport

ODH Violence and Injury Prevention Section
https://odh.ohio.gov/know-our-programs/child-injury-Prevention/vipp

Department of Health

Department of Health
Ohio Injury Prevention Partnership
Child Injury Action Group

I have read the Ohio Department of Health's Concussion Information Sheet and understand that I have a responsibility to report my/my child's symptoms to coaches, administrators, and health care provider. I also understand that I/my child must have no symptoms before return to play can occur.

Athlete Name (please print):_____

Parent/Guardian Signature: _____

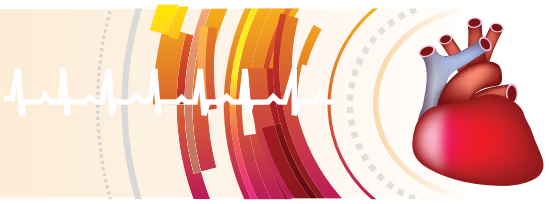
Date: _____

Ohio Department of Health
Violence and Injury Prevention Section
246 North High Street, 5th Floor
Columbus, OH 43215
(614) 466-2144

http://www.odh.ohio.gov/concussion

Sudden Cardiac Arrest and Lindsay's Law

Parent/Athlete Signature Form



What is Lindsay's Law? Lindsay's Law is about Sudden Cardiac Arrest (SCA) in youth athletes. It covers all athletes 19 years or younger who practice for or compete in athletic activities. Activities may be organized by a school or youth sports organization.

Which youth athletic activities are included in Lindsay's law?

- Athletics at all schools in Ohio (public and non-public)
- Any athletic contest or competition sponsored by or associated with a school
- All interscholastic athletics, including all practices, interschool practices and scrimmages
- All youth sports organizations
- All cheerleading and club sports, including noncompetitive cheerleading

What is SCA? SCA is when the heart stops beating suddenly and unexpectedly. This cuts off blood flow to the brain and other vital organs. People with SCA will die if not treated immediately. SCA can be caused by 1) a structural issue with the heart, OR 2) an heart electrical problem which controls the heartbeat, OR 3) a situation such as a person who is hit in the chest or a gets a heart infection.

What is a warning sign for SCA? If a family member died suddenly before age 50, or a family member has cardiomyopathy, long QT syndrome, Marfan syndrome or other rhythm problems of the heart.

What symptoms are a warning sign of SCA? A young athlete may have these things with exercise:

- Chest pain/discomfort
- Unexplained fainting/near fainting or dizziness
- Unexplained tiredness, shortness of breath or difficulty breathing
- Unusually fast or racing heart beats

What happens if an athlete experiences syncope or fainting before, during or after a practice, scrimmage, or competitive play? The coach MUST remove the youth athlete from activity immediately. The youth athlete MUST be seen and cleared by a health care provider before returning to activity. This written clearance must be shared with a school or sports official.

What happens if an athlete experiences any other warning signs of SCA? The youth athlete should be seen by a health care professional.

Who can evaluate and clear youth athletes? A physician (MD or DO), a certified nurse practitioner, a clinical nurse specialist, certified nurse midwife. For school athletes, a physician's assistant or licensed athletic trainer may also clear a student. That person may refer the youth to another health care provider for further evaluation.

What is needed for the youth athlete to return to the activity? There must be clearance from the health care provider in writing. This must be given to the coach and school or sports official before return to activity.

All youth athletes and their parents/guardians must review information about Sudden Cardiac Arrest, then sign and return this form.

_____	_____
Parent/Guardian Signature	Student Signature
_____	_____
Parent/Guardian Name (Print)	Student Name (Print)
_____	_____
Date	Date