KIPP HOUSTON PUBLIC SCHOOLS ATHLETICS

STUDENT-ATHLETE HANDBOOK ACKNOWLEDGEMENT 2018-2019

Upon review of the KIPP Houston Public Schools Student-Athlete Handbook for 2018-2019, please complete the information below, sign, and return this page to your Head Coach or Campus Athletic Director.

I have read the KHPS Student-Athlete Handbook for 2018-2019 and will abide by the guidelines and procedures of the KHPS Athletics Department.

I understand that I can review a hard copy of this document at my campus.

My signature certifies that I have read the KHPS Student-Athlete Handbook for 2018-2019.

_____

(Student-Athlete name) *(Student-Athlete Signature)* *(Date)*

_____

(Parent/Guardian name) *(Parent/Guardian Signature)* *(Date)*

The development of this form is credited to the TEA/UIL, but has been edited for HCAL purposes. This form is being utilized because all member schools are governed by the Texas Education Agency.

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

2017

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent (or guardian) and student in order for the student to participate in athletic activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an athletic event.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____

Address _____ Phone _____

Grade _____ School _____

Personal Physician _____ Phone _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers in the box below**. Circle questions you don't know the answers to.

		Yes	No
1.	Have you had a medical illness or injury since your last check up or sports physical?	☐	☐
2.	Have you been hospitalized overnight in the past year?	☐	☐
	Have you ever had surgery?	☐	☐
3.	Have you ever had prior testing for the heart ordered by a physician?	☐	☐
	Have you ever passed out during or after exercise?	☐	☐
	Have you ever had chest pain during or after exercise?	☐	☐
	Do you get tired more quickly than your friends do during exercise?	☐	☐
	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
	Have you had high blood pressure or high cholesterol?	☐	☐
	Have you ever been told you have a heart murmur?	☐	☐
	Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	☐	☐
	Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	☐	☐
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
4.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
	If yes, how many times? _____		
	When was your last concussion? _____		
	How severe was each one? (Explain below)		
	Have you ever had a seizure?	☐	☐
	Do you have frequent or severe headaches?	☐	☐
	Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
5.	Are you missing any paired organs?	☐	☐
6.	Are you under a doctor's care?	☐	☐
7.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
8.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
9.	Have you ever been dizzy during or after exercise?	☐	☐
10.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
11.	Have you ever become ill from exercising in the heat?	☐	☐
12.	Have you had any problems with your eyes or vision?	☐	☐

		Yes	No
13.	Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
14.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
15.	Have you ever had a sprain, strain, or swelling after injury?	☐	☐
	Have you broken or fractured any bones or dislocated any joints?	☐	☐
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐
	If yes, check appropriate box and explain below:		

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm	☐ Foot	

16.	Do you want to weight more or less than you do now?	☐	☐
17.	Do you feel stressed out?	☐	☐
18.	Have you ever been diagnosed with or treated for sickle cell trait or cell disease?	☐	☐

Females Only

19. When was your first menstrual period? _____
When was your most recent menstrual period? _____
How much time do you usually have from the start of one period to the start of another? _____
How many periods have you had in the last year? _____
What was the longest time between periods in the last year? _____

Males Only

20. Do you have two testicles? _____
21. Do you have any testicular swelling or masses? _____

An individual answering in the affirmative to any question relating to a possible cardiovascular health issue (question three above), as identified on the form, should be restricted from further participation until the individual is examined and cleared by a physician, physician assistant, chiropractor, or nurse practitioner.

**EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):

_____

_____

_____

_____

It is understood that even though protective equipment is worn by the athlete, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of athletic competition, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the Houston Charter Athletic League

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in HCAL practices, games or matches. THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth_____

Height _____ Weight_____ % Body fat (optional) _____ Pulse _____ BP____/____ (____/____, ____/____)
brachial blood pressure while sitting

Vision: R 20/_____ L 20/___ Corrected: ☐ Y ☐ N Pupils: ☐ Equal ☐ Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high athletic participation and again prior to first and third years of high school athletic participation. It ***must*** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. **** Local district policy may require an annual physical exam.***

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

☐ Not cleared for:_____Reason: _____

Recommendations: _____

_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type) _____ Date of Examination: _____

Address: _____

Phone Number: _____

Signature: _____

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or games/matches.

EVALUACIÓN FÍSICA DE PRE-PARTICIPACIÓN – EXPEDIENTE MÉDICO

REVISED 1-6-09

Este FORMULARIO DEL EXPEDIENTE MÉDICO debe completarse cada año por los padres (o tutores) y el estudiante para que el estudiante pueda participar en actividades deportivas. Estas preguntas están diseñadas para determinar si el estudiante ha desarrollado alguna condición potencialmente peligrosa para participar en un evento atlético.

Nombre del estudiante: (anote)_____ Sexo _____ Edad _____ Fecha de nacimiento_____

Dirección _____ Teléfono _____

Grado _____ Escuela _____

Médico personal _____ Teléfono _____

En caso de emergencia llamar:

Nombre _____ Parentezco _____ Teléfono(C)_____ (T)_____

Explique las respuestas "Sí" en el cuadro de abajo. ** Circule las preguntas donde no sepa las respuestas. ***Cualquier respuesta afirmativa a las preguntas 1, 2, 3, 4, 5 ó 6 requiere más evaluaciones médicas inclusive un examen físico. Se requiere la autorización por escrito de un médico, asistente médico, quiropráctico o enfermera antes de cualquier participación en las prácticas de los juegos o partidos UIL.***

	Sí	No
1. ¿Has tenido una enfermedad o lesión desde tu último chequeo o examen fisico para deportes?	☐	☐
2. ¿Has pasado una noche hospitalizado durante el último año?	☐	☐
¿Alguna vez has tenido una cirugía?	☐	☐
3. ¿Alguna vez te has desmayado durante o después del ejercicio?	☐	☐
¿Has tenido dolor en el pecho durante o después del ejercicio?	☐	☐
¿Te cansas más rápido que tus amigos al hacer ejercicio?	☐	☐
¿Alguna vez sientes acelerado el corazón, o te saltan los latidos del corazón?	☐	☐
¿Has tenido la presión arterial alta o colesterol alto?	☐	☐
¿Alguna vez te han dicho que tienes un soplo cardíaco?	☐	☐
¿Algún familiar o pariente murió de problemas cardíacos o de muerte súbita antes de los 50 años?	☐	☐
¿Algún miembro de tu familia ha sido diagnosticados con agrandamiento del corazón, (cardiomiocardiopatía dilatada), cardiomio-cardiopatía hipertrófica, mayor síndrome de QT largo u otra enfermedad de los canales iónicos (el síndrome Brugada,etc), el síndrome de Marfan, o ritmo cardíaco anormal?	☐	☐
¿Has tenido una infección viral severa (por ejemplo miocarditis o mononucleosis) durante el último mes?	☐	☐
¿Alguna vez tu médico te ha negado o restringido tu participación en deportes por problemas del corazón?	☐	☐
4. ¿Has tenido una lesión en la cabeza o conmoción cerebral?	☐	☐
¿Alguna vez te han noqueado, perdiste el conocimiento o la memoria?	☐	☐

En caso afirmativo, ¿cuántas veces? _____ ¿Cuándo fue la última conmoción?_____

¿Qué tan severa fue cada lesión? (Explicar abajo)		
¿Alguna vez has tenido una convulsión?	☐	☐
¿Tienes fuertes dolores de cabeza frecuentemente?	☐	☐
¿Alguna vez has tenido entumecimiento u hormigueo en los brazos, las manos, las piernas o los pies?	☐	☐
¿Alguna vez has tenido un nervio pellizcado, que pica, arde?	☐	☐
5. ¿Te falta algún órgano par?	☐	☐
6. ¿Estás bajo el cuidado de un médico?	☐	☐
7. ¿Estás tomando medicamento con o sin receta, medicamento o píldoras o usas un inhalador?	☐	☐
8. ¿Padeces alergias (por ejemplo: al polen, la medicina, alimentos, o picaduras de insectos)?	☐	☐
9. ¿Alguna vez te has sentido mareado durante o después del ejercicio?	☐	☐
10. ¿Tienes algún problema de la piel (por ejemplo, picazón, erupciones cutáneas, acné, verrugas, hongos o ampollas)?	☐	☐
11. ¿Alguna vez has enfermado por hacer ejercicio cuando hace calor?	☐	☐
12. ¿Has tenido algún problema con tus ojos o visión?	☐	☐

	Sí	No
13. ¿Alguna vez te ha faltado inesperadamente el aire al hacer ejercicio?	☐	☐
¿Tienes asma?	☐	☐
¿Tienes alergias estacionales que requieran tratamiento médico?	☐	☐
14. ¿Utilizas algún equipo de protección especial o correctiva o dispositivos que no se utilizan generalmente para la práctica deportiva o la posición (por ejemplo, rodillera, protector especial para el cuello, plantillas, protector de dientes, aparato auditivo)?	☐	☐
15. ¿Alguna vez has tenido un esguince, torcedura o hinchazón después de una lesión?	☐	☐
¿Te has roto o fracturado algún hueso o dislocado alguna articulación?	☐	☐
¿Has tenido algún otro problema con dolor o hinchazón en músculos, tendones, huesos o articulaciones?	☐	☐

☐ Cabeza	☐ Codo	☐ Cadera
☐ Cuello	☐ Antebrazo	☐ Muslo
☐ Espalda	☐ Muñeca	☐ Rodilla
☐ Pecho	☐ Mano	☐ Espinilla/Pantorrilla
☐ Hombro	☐ Dedo	☐ Tobillo
☐ Brazo superior		☐ Pie

16. ¿Quieres pesar más o menos de lo que pesas ahora?	☐	☐
¿Pierdes peso regularmente para cumplir con los requisitos de tu deporte?	☐	☐
17. ¿Te sientes estresado?	☐	☐
18. ¿Has sido diagnosticado o recibido tratamiento por el rasgo o enfermedad de células falciformes?	☐	☐

19. ***Solamente mujeres***

¿Cuándo fue tu primer periodo menstrual? _____

¿Cuándo fue la última fecha de tu periodo menstrual? _____

¿Cuántos días pasan entre el inicio de tu periodo hasta el siguiente?

¿Cuántos periodos tuviste el año pasado? _____

¿Cuál fue el tiempo más largo entre tus periodos el año pasado? _____

El individuo que responde afirmativamente a todas las preguntas relacionadas con asuntos de salud cardiovasculares (tercera pregunta) debe tener restricciones en su participación deportiva hasta que el individuo sea examinado y autorizado por un médico, asistente médico, quiropráctico o enfermera).

** ***EXPLICAR respuestas afirmativas En el siguientecuadro (adjuntar otra hoja si es necesario):***

_____

_____

_____

Se entiende que aunque el atleta use equipo de protección cuando sea necesario, siempre existe la posibilidad de un accidente. La Liga-interescolar universitaria ni la escuela, asumen ninguna esponsabilidad en caso de que ocurra un accidente.

Si a juicio de cualquier representante de la escuela, el estudiante necesita atención inmediata y tratamiento como consecuencia de una lesión o enfermedad, por medio de la presente solicito, autorizo y doy mi consentimiento para su atención y tratamientos para dicho estudiante por cualquier médico, entrenador, enfermera o representante de la escuela. Me comprometo a indemnizar y eximir de responsabilidad a la escuela y al representante de la escuela o del hospital de cualquier reclamo por cualquier persona por razones de cuidado y tratamiento de dicho estudiante.

Si entre esta fecha y el comienzo de la competencia atlética, ocurre una enfermedad o lesión que pueda limitar la participación del estudiante, estoy de acuerdo en notificar a la escuela o autoridad sobre dicha enfermedad o lesión.

Por medio de la presente declaro que en lo que corresponde a mi conocimiento, mis respuestas están completas y correctas. No responder con la verdad podría implicar para el estudiante, sanciones determinadas por UIL.

Firma del estudiante:_____ ***Firma del padre o tutor:*** _____ ***Fecha:***_____

THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature_____

EVALUACIÓN FÍSICA DE PRE-PARTICIPACIÓN—EXAMEN FÍSICO

Nombre del estudiante:_____ Sexo:_____ Edad: _____ Fecha de nacimiento:_____

Altura:_____ Peso:_____ % Grasa corporal (opcional) _____ Peso:_____ BP____/____ (____/____, ____/____)
Presión arterial branquial mientras está sentado

Visión: R 20/_____ L 20/___ Corregida: **S** N Pupilas: **Igual** **Desigual**

Como requisito mínimo, este **Formulario de evaluación físico** deberá completarse antes de participar en eventos atléticos de la secundaria y nuevamente antes del primer y tercer año de participación atlética en la preparatoria. Debe ***ser*** completado y detallar las respuestas afirmativas especificadas en el formulario del historial médico al reverso. ****Las nomas locales del distrito pueden requerir un examen físico anual.***

	NORMAL	ANORMAL	INICIALES*
MÉDICO			
Apariencia			
Ojos/oídos/ Nariz/garganta			
Ganglios linfáticos			
Auscultación del corazón en posición supina.			
Auscultación del corazón en posición de pié.			
Pulsos del corazón en extremidades bajas			
Pulsos			
Pulmones			
Abdomen			
Genitales (solamente hombres)			
Piel			
Estigma de Marfan (aracnodactilia, pectus excavatum, hipermovilidad de las coyunturas, escoliosis)			
APARATO LOCOMOTOR			
Cuello			
Espalda			
Hombro/brazo			
Codo/antebrazo			
Muñeca/mano			
Cadera/muslo			
Rodilla			
Pierna/Tobillo			
Pierna/Tobillo			

* solamente examen de estación

AUTORIZADO

☐ Autorizado

☐ Autorizado después de completar la evaluación o rehabilitación para:_____

_____

☐ No autorizado para:_____ Razón:_____

Recomendaciones _____

_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type) _____ Date of Examination:_____

Address:_____

Phone Number: _____

Signature:_____

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or games/matches.

SUDDEN CARDIAC AWARENESS FORM

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Name of Student: _____

What is Sudden Cardiac Arrest?

- Occurs suddenly and often without warning.
- 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.
- 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 immediately.

What causes Sudden Cardiac Arrest?

- **Conditions present at birth**
  - ***Inherited*** *(passed on from parents/relatives)* ***conditions of the heart muscle:***
    - **Hypertrophic Cardiomyopathy** – hypertrophy (thickening) of the left ventricle; the most common cause of sudden cardiac arrest in athletes in the U.S.
    - **Arrhythmogenic Right Ventricular Cardiomyopathy** – replacement of part of the right ventricle by fat and scar; the most common cause of sudden cardiac arrest in Italy.
    - **Marfan Syndrome** – a disorder of the structure of blood vessels that makes them prone to rupture; often associated with very long arms and unusually flexible joints.
  - ***Inherited conditions of the electrical system:***
    - **Long QT Syndrome** – abnormality in the ion channels (electrical system) of the heart.
    - **Catecholaminergic Polymorphic Ventricular Tachycardia and Brugada Syndrome** other types of electrical abnormalities that are rare but are inherited.
  - ***NonInherited*** *(not passed on from the family, but still present at birth)* ***conditions:***
    - **Coronary Artery Abnormalities** – abnormality of the blood vessels that supply blood to the heart muscle. The second most common cause of sudden cardiac arrest in athletes in the U.S.
    - **Aortic valve abnormalities** – failure of the aortic valve (the valve between the heart and the aorta) to develop properly; usually causes a loud heart murmur.
    - **Non---compaction Cardiomyopathy** – a condition where the heart muscle does not develop normally.
    - **Wolff---Parkinson---White Syndrome** – an extra conducting fiber is present in the heart's electrical system and can increase the risk of arrhythmias.
- **Conditions not present at birth but acquired later in life:**
  - **Commotio Cordis** – concussion of the heart that can occur from being hit in the chest by a ball, puck, or fist.
  - **Myocarditis** – infection/inflammation of the heart, usually caused by a virus.
  - **Recreational/Performance---Enhancing drug use**.
- **Idiopathic**: Sometimes the underlying cause of the Sudden Cardiac Arrest is unknown, even after autopsy

yesprep PUBLIC SCHOOLS

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 that occur while exercising may necessitate further evaluation from your physician before returning to practice or a game.

What is the treatment for Sudden Cardiac Arrest?

- Time is critical and an immediate response is vital.
- **CALL 911**
- **Begin CPR**
- **Use an Automated External Defibrillator (AED)**

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 HCAL *Pre---Participation Physical Evaluation – Medical History* form includes ALL 12 of these important cardiac elements and is mandatory annually**.
- Additional screening using an electrocardiogram and/or an echocardiogram is readily available to all athletes, but is not mandatory.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian Name (Print)

_____ _____

Student Signature Date

_____

Student Name (Print)

KIPP HOUSTON PUBLIC SCHOOLS ATHLETICS

CONCUSSION ACKNOWLEDGEMENT FORM

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Name of Student _____

Definition of Concussion - means a complex pathophysiological process affecting the brain caused by a traumatic physical force or impact to the head or body, which may: (A) include temporary or prolonged altered brain function resulting in physical, cognitive, or emotional symptoms or altered sleep patterns; and (B) involve loss of consciousness.

Prevention – Teach and practice safe play & proper technique.

- Follow the rules of play.
- Make sure the required protective equipment is worn for all practices and games.
- Protective equipment must fit properly and be inspected on a regular basis.

Signs and Symptoms of Concussion – The signs and symptoms of concussion may include but are not limited to: Head ache, appears to be dazed or stunned, tinnitus (ringing in the ears), fatigue, slurred speech, nausea or vomiting, dizziness, loss of balance, blurry vision, sensitive to light or noise, feel foggy or groggy, memory loss, or confusion.

Oversight - Each district shall appoint and approve a Concussion Oversight Team (COT). The COT shall include at least one physician and an athletic trainer if one is employed by the school district. Other members may include: Advanced Practice Nurse, neuropsychologist or a physician's assistant. The COT is charged with developing the Return to Play protocol based on peer reviewed scientific evidence.

Treatment of Concussion - The student-athlete shall be removed from practice or competition immediately if suspected to have sustained a concussion. Every student-athlete suspected of sustaining a concussion shall be seen by a physician before they may return to athletic participation. The treatment for concussion is cognitive rest. Students should limit external stimulation such as watching television, playing video games, sending text messages, use of computer, and bright lights. When all signs and symptoms of concussion have cleared and the student has received written clearance from a physician, the student-athlete may begin their district's Return to Play protocol as determined by the Concussion Oversight Team.

Return to Play - According to the Texas Education Code, Section 38.157:
A student removed from an interscholastic athletics practice or competition under Section 38.156 may not be permitted to practice or compete again following the force or impact believed to have caused the concussion until:

(1) the student has been evaluated, using established medical protocols based on peer-reviewed scientific evidence, by a treating physician chosen by the student or the student 's parent or guardian or another person with legal authority to make medical decisions for the student;

(2) the student has successfully completed each requirement of the return-to-play protocol established under Section 38.153 necessary for the student to return to play;

(3) the treating physician has provided a written statement indicating that, in the physician 's professional judgment, it is safe for the student to return to play; and

(4) the student and the student 's parent or guardian or another person with legal authority to make medical decisions for the student:

(A) have acknowledged that the student has completed the requirements of the return-to-play protocol necessary for the student to return to play;

(B) have provided the treating physician 's written statement under Subdivision (3) to the person responsible for compliance with the return-to-play protocol under Subsection (c) and the person who has supervisory responsibilities under Subsection (c); and

(C) have signed a consent form indicating that the person signing:

(i) has been informed concerning and consents to the student participating in returning to play in accordance with the return-to- play protocol;

(ii) understands the risks associated with the student returning to play and will comply with any ongoing requirements in the return-to-play protocol;

(iii) consents to the disclosure to appropriate persons, consistent with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), of the treating physician 's written statement under Subdivision (3) and, if any, the return-to-play recommendations of the treating physician; and

(iv) understands the immunity provisions under Section 38.159.

Parent or Guardian Signature _____Date _____ / Student-Athlete Signature _____ Date _____

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Parent and Student Agreement/Acknowledgement Form
Anabolic Steroid Use and Random Steroid Testing

- Texas state law prohibits possessing, dispensing, delivering or administering a steroid in a manner not allowed by state law.
- Texas state law also provides that body building, muscle enhancement or the increase in muscle bulk or strength through the use of a steroid by a person who is in good health is not a valid medical purpose.
- Texas state law requires that only a licensed practitioner with prescriptive authority may prescribe a steroid for a person.
- Any violation of state law concerning steroids is a criminal offense punishable by confinement in jail or imprisonment in the Texas Department of Criminal Justice.

STUDENT ACKNOWLEDGEMENT AND AGREEMENT

As a prerequisite to participation in HCAL athletic activities, I agree that I will not use anabolic steroids. I have read this form and understand that I may be asked to submit to testing for the presence of anabolic steroids in my body, and I do hereby agree to submit to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my high school. I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject me to penalties as determined by HCAL.

Student Name (Print): _____ Grade (9-12) _____

Student Signature: _____ Date: _____

PARENT/GUARDIAN CERTIFICATION AND ACKNOWLEDGEMENT

As a prerequisite to participation by my student in HCAL athletic activities, I certify and acknowledge that I have read this form and understand that my student must refrain from anabolic steroid use and may be asked to submit to testing for the presence of anabolic steroids in his/her body. I do hereby agree to submit my child to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my student's high school. I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject my student to penalties as determined by HCAL.

Name (Print): _____

Signature: _____ Date: _____

Relationship to student: _____

School Year (to be completed annually) _____