The Nebraska State School Law, in part, requires a physical exam for entrance into seventh grade. A complete dental check-up is strongly encouraged at this time also.

If you do not wish to provide evidence of a physical exam, a signed statement waiving this requirement must be submitted to the school by November 1 (or 60 days after enrollment). Please note, if your child will be participating in competitive athletics, a physical examination by a licensed health care provider is required and signing a waiver does not satisfy this requirement.

Physical Education Restrictions/Exemptions: Middle or high school students who have restrictions for participation in PE must have a health care provider's order on file, delineating what the restrictions are. Students who cannot participate because of health related concerns must have a health care provider's note on file exempting them from the class.

The following forms are necessary for a 7th grade physical: The Health Exam Card and Preparticipation History Form are necessary for a school physical only. The Athletic Insurance Coverage, NSAA/OPS Student/Parent Consent, Head Injury/Concussion Acknowledgement, Concussion Information and Fact Sheet, and Guidelines for Concussion Management are necessary for participation in after-school sports.

Athletic physicals are necessary for anyone participating in an after-school sport. Having the Preparticipation History Form filled out in advance by the student and parent will not cause a delay should your student choose to participate in a sport at a later date.

History Form to be completed/signed by student before 7th grade physical with review and sign off by parent for possible future athletic participation. Health care provider completes Health Exam Card and reviews History Form. For participation in after-school sports, Insurance and Consent Form completed by student and parent. The Head Injury/Concussion Acknowledgement is to be reviewed and signed by student and parent.

OMAHA PUBLIC SCHOOLS – Student Form

ATHLETIC INSURANCE COVERAGE

Your school, acting for members of the athletic squad, makes available an Athletic Injury Benefit Plan approved by the Omaha Board of Education. The total premium is paid by the student or parent. The purpose of such coverage is to assist in the cost of treatment of accidental injury. Payments are in addition to any payments by another company for the same injury.

SQUAD MEMBERS MUST HAVE INSURANCE COVERAGE TO PARTICIPATE.

Check the statements that apply:

_____ I shall participate in the Athletic Benefit Injury Plan. Information brochures, if not attached, are available from the school office upon request.

_____ I have accident injury coverage with the ________________________________ Insurance Company.

POLICY NO. __________________________ Signature of Parent/Guardian __________________________

Date __________________________ Address __________________________

Note: This form is to be filled out completely and filed in the office of the school before student is allowed to practice and/or compete.
Preparticipation Physical Evaluation

Date of Exam ________________________________

Name ______________________________________ Sex __________________ Age ______ Date of Birth __________________

Grade _______ School __________________ Sport(s) __________________

Address ____________________________________ Phone __________________

Personal physician ____________________________

In case of emergency, contact

Name ______________________________________ Relationship ____________________ Phone (H) ___________________ (W) __________________

Explain “YES” answers below. Circle questions you do not know the answers to.

1. Has a doctor ever denied or restricted your participation in sports for any reason? YES NO

2. Do you have an ongoing medical condition? (like diabetes or asthma) YES NO

3. Are you currently taking any prescriptions or nonprescription (over-the-counter) medicines or pills? YES NO

4. Do you have allergies to medicines, pollens, foods, or stinging insects? YES NO

5. Have you ever passed out or nearly passed out DURING exercise? YES NO

6. Have you ever passed out or nearly passed out AFTER exercise? YES NO

7. Have you ever had discomfort, pain, or pressure in your chest during exercise? YES NO

8. Does your heart race or skip beats during exercise? YES NO

9. Has a doctor ever told you that you have (check all that apply):
   - High blood pressure
   - A heart murmur
   - High cholesterol
   - A heart infection

   (for example, ECG, echocardiogram)

10. Has a doctor ever ordered a test for your heart? YES NO

11. Has anyone in your family died for no apparent reason? YES NO

12. Does anyone in your family have a heart problem? YES NO

13. Does anyone in your family have Marfan syndrome? YES NO

14. Has any family member or relative died of heart problems or of sudden death before age 50? YES NO

15. Have you ever had surgery? YES NO

16. Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches? YES NO

17. Have you ever had an injury, like a sprain, muscle or ligament tear or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below. YES NO

18. Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast or crutches? YES NO

19. Have you been hit in the head and been confused or lost your memory? YES NO

20. Have you ever had a stress fracture? YES NO

21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? YES NO

22. Do you regularly use a brace or assistive device? YES NO

23. Has a doctor ever told you that you have asthma or allergies? YES NO

24. Do you cough, wheeze, or have difficulty breathing during or after exercise? YES NO

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

Signature of athlete ________________________ Signature of parent/guardian __________________ Date __________________

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

Parent or Legal guardian signature __________________ Date __________________

# OPS Pre-Participation Physical Exam
## Supplemental Questions

<table>
<thead>
<tr>
<th>Cardiovascular Health</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has a doctor ever told you that you have any heart problems? If so, check all that apply:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>______ High blood pressure</td>
<td>______ A heart murmur</td>
<td>______ High cholesterol</td>
</tr>
<tr>
<td>______ A heart infection</td>
<td>______ Kawasaki Disease</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you get light headed or feel more short of breath than expected during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you get more tired or short of breath more quickly than your friends during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Has any family member or relative died of heart problems or had an unexpected or unexplained death before age 50 (including drowning, unexplained car accident, or Sudden Infant Death Syndrome)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Does anyone in your family have hypertrophic cardiomyopathy, Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy, Long QT Syndrome, Short QT Syndrome, Brugada Syndrome, a catecholaminergic polymorphic ventricular tachycardia?</td>
<td></td>
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<tr>
<td>6. Does anyone in your family have a heart problem, pace maker, or implanted defibrillator?</td>
<td></td>
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<tr>
<td>7. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?</td>
<td></td>
<td></td>
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<tr>
<td>Bone and Joint Health</td>
<td></td>
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<tr>
<td>8. Do you have any bone, muscle, or joint injury that bothers you?</td>
<td></td>
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<tr>
<td>9. Do any of your joints become painful, swollen, feel warm, or look red?</td>
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<tr>
<td>10. Do you have any history of juvenile arthritis or connective tissue disease?</td>
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<tr>
<td>General Medical</td>
<td></td>
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<tr>
<td>11. Have you had a herpes or MRSA skin infection?</td>
<td></td>
<td></td>
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<tr>
<td>12. Have you had any eye injuries?</td>
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<td></td>
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</tbody>
</table>
OMAHA PUBLIC SCHOOLS
HEALTH EXAMINATION CARD

Last Name ______________________ First Name ______________________ Birthday __________ Gender: M ___ F ___
Address __________________________________ Phone __________ School _____________ Grade ______
Parent or Guardian’s Name ________________________________________________________________
Name of Health Care Provider ____________________________________________________________

IMMUNIZATIONS (obtain a copy of the immunization record if possible)

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Month/Day/Year</th>
<th>Immunization</th>
<th>Month/Day/Year</th>
<th>Immunization</th>
<th>Month/Day/Year</th>
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<tr>
<td>DTaP 1</td>
<td><em><strong>/</strong></em>/____</td>
<td>Polio 1</td>
<td><em><strong>/</strong></em>/____</td>
<td>HEP B</td>
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<td>MMR 1</td>
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<td>HEP A</td>
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<td>Tdap 1</td>
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<td>HIB 1</td>
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<td>TB skin test</td>
<td>Result</td>
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<td>VZV 1</td>
<td><em><strong>/</strong></em>/____</td>
<td>Prevnar 1</td>
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<td>Date parent reported disease</td>
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<td>Influenza</td>
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<tr>
<td>HPV 1</td>
<td><em><strong>/</strong></em>/____</td>
<td>Meningococcal</td>
<td><em><strong>/</strong></em>/____</td>
<td>Other</td>
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</tbody>
</table>

HEALTH HISTORY

_____ Fainting      _____ Head Injury      _____ Asthma
_____ Seizure       _____ Surgery        _____ Allergies
Other, describe ____________________________

_____ Family history of sudden death prior to age 50 __________________________

PHYSICAL EXAMINATION

General Appearance ______________________ Height _______ Weight _______ BMI _______
Lab: HCT or HGB _________________________ Lead level drawn __________ Yes ___ No ___ BP _______
Skeletal Development ____________________ Posture __________ Scoliosis __________
Hair/Skin _______________________________ Lymph __________ Head/Neck __________
Ears ________________________________ Nose/Sinus ______________ Throat ______________
Mouth _________________________________ Dental __________________ Speech ______________
Heart ________________________________ Rhythm _______ Rate _______ Chest/Lungs ________

(over)
Abdomen ________________________________________________

Extremities ____________________________

Neurological Exam ________________________________

Mental development assessment ____________________________

Medical diagnosis _______________________________________

Is this child subject to any condition limiting classroom or physical activities? ___ No        ___ Yes

If “Yes”, describe ______________________________________

Is this child taking any medication? ___No   ___Yes   if “Yes”, list medications ____________________________

List concerns/remarks ____________________________

_____________________________________________________

HEARING SCREENING: _______Pass   _____Fail       Referral______________________

Audio Test                        500Hz   1000Hz   2000Hz   4000Hz
Right Ear---dB _____________________  ______  ______  ______  ______
Left Ear ----dB _____________________  ______  ______  ______  ______

VISION EXAM required for Kindergarten and students transferring from outside of NE

Tests                         Pass  Fail  Recommend Further Examination
Amblyopia   ____  ____   _____
Strabismus   ____  ____   _____
Internal Eye Health  ____  ____   _____
External Eye Health  ____  ____   _____

Visual Acuity    Right 20/_____ Left 20/_____with/without glasses

Comment/Recommendations/Restrictions

_____________________________________________________________________________________

_____________________________________________________________________________________

___________  ___________________________________  ____________
Date of PE   Signature of Licensed Health Care Provider  Office Phone #
NEBRASKA SCHOOL ACTIVITIES ASSOCIATION (NSAA)/Omaha Public Schools (OPS)
Student and Parent Consent Acknowledgement and Release Form

School Year - 20____ - 20____ Member School: ________________________________

Name of Student: ___________________________________________________________

Date of Birth: ____________________ Place of Birth: ____________________________

The undersigned(s) are the student and the parent(s), or guardian(s) in charge of the above named student and are collectively referred to as “Parent”.

The Parent and Student hereby:

(1) Understand and agree that participation in NSAA sponsored activities is voluntary on the part of the Student and is a privilege;

(2) Understand and agree that (a) by this Consent Form the NSAA has provided to the Parent and Student of the existence of potential dangers associated with athletic participation; (b) participation in any athletic activity may involve injury of some type; (c) the severity of such injury can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries to the body’s bones, joints, ligaments, tendons, or muscles to catastrophic injuries to the head, neck and spinal cord, and on rare occasions, injuries so severe as to result in total disability, paralysis and death; (d) even the best coaching, the use of the best protective equipment and strict observance of the rules. Injuries are still a possibility;

(3) Consent and agree to participation of the Student in NSAA activities subject to all NSAA by-laws and rules interpretations for participation in NSAA sponsored activities, and the activities rules of the NSAA member school for which the Student is participating; and;

(4) Consent and agree to (a) the disclosure by the Member school at which the Student is enrolled in the NSAA, and subsequent disclosure by the NSAA, of information regarding the Student, including the student’s name, address, telephone listing, electronic mail address, photograph, date of and place of birth, major field of study, dates of attendance, grade level, enrollment status (e.g., full-time or part-time), participation in officially recognized activities and sports, weight and height of as a member of athletic teams, degrees, honors and awards received, statistics regarding performance, records or documentation related to eligibility for NSAA sponsored activities, medical records, and any other information related to the Student’s participation in NSAA sponsored activities; and (b) the Student being photographed, video taped, audio taped, or recorded by any other means while participating in NSAA activities and contests, consent to and waive any privacy rights with regard to the display of such photographs or recordings, and waive any claims of ownership or other rights with regard to such photographs or recordings or to the broadcast, sale or display of such photographs or recordings.

(5) Consent and agree for the above named student to accompany any school team of which he/she is a member on any of its local or out-of-town trips. I/We authorize the school to obtain, through a physician of its own choice, any emergency medical care that may become reasonably necessary in the course of such athletic activities or travel.

(6) WITH FULL UNDERSTANDING OF THE RISKS INVOLVED, RELEASE, INDEMNIFY, AND HOLD HARMLESS THE OMAHA PUBLIC SCHOOLS AND ITS OFFICERS, AGENTS, REPRESENTATIVES, AND EMPLOYEES (COLLECTIVELY THE “RELEASEES”) FROM ANY AND ALL LOSSES, CLAIMS, DEMANDS, ACTIONS AND CAUSES OF ACTION, OBLIGATION, DAMAGES, AND COSTS OR EXPENSES OF ANY NATURE (INCLUDING ATTORNEY’S FEES) THAT THE STUDENT AND OR PARENTAL/LEGAL GUARDIAN INCUR OR SUSTAIN TO PERSON, PROPERTY OR BOTH, WHICH ARISE OUT OF, RESULT FROM, OCCUR DURING OR ARE OTHERWISE CONNECTED WITH THE STUDENT’S PARTICIPATION IN NSAA OR OMAHA PUBLIC SCHOOLS ACTIVITIES OR TRAVEL RELATED TO SUCH ACTIVITIES IF DUE TO ACCIDENT, MISHAP, OR ORDINARY NEGLIGENCE OF THE RELEASEES.

I acknowledge that I have read paragraphs (1) through (6) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in athletic activities and the release.

WE HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE PROVISION.

Dated this ______ day of __________________, ________.

Name of Student [Print Name] Student Signature

(I am) (We are) the [circle the appropriate choice] (Parent) (Guardian). (I) (We) acknowledge that (I) (We) have read paragraphs (1) through (6) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities. Having read the warning in paragraph (3) above and understanding the potential risk of injury to my Student, (I) (We) hereby give (my) (our) permission for ____________________ [insert student name] to practice and compete for the above named high school/middle school in activities approved by the NSAA, except those crossed out below:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Activity</th>
<th>Activity</th>
<th>Activity</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseball</td>
<td>Golf</td>
<td>Tennis</td>
<td>Debate</td>
<td>Speech</td>
</tr>
<tr>
<td>Basketball</td>
<td>Swimming</td>
<td>Track</td>
<td>Journalism</td>
<td></td>
</tr>
<tr>
<td>Cross Country</td>
<td>Soccer</td>
<td>Volleyball</td>
<td>Music</td>
<td></td>
</tr>
<tr>
<td>Football</td>
<td>Softball</td>
<td>Wrestling</td>
<td>Play Production</td>
<td></td>
</tr>
</tbody>
</table>

Dated the ______ day of __________________, ________.

Parent/Guardian [Print Name] Parent/Guardian Signature
OMAHA PUBLIC SCHOOLS HEAD INJURY/CONCUSSION ACKNOWLEDGEMENT FORM

I understand there is a possibility that participation in any sport may result in a head injury and/or concussion. Furthermore, I have been provided with the Omaha Public Schools Sports Medicine Advisory Committee Parent and Student Athlete Concussion Information and Fact Sheet and understand the importance of reporting a head injury and/or concussion to parents, coaches and athletic training staff.

After reading the Omaha Public Schools Sports Medicine Advisory Committee Parent and Student Athlete Concussion Information and Fact Sheet, I am aware of the following information:

• A concussion is a brain injury, which I am responsible for reporting;

• A concussion can affect one’s ability to perform everyday activities, affect reaction time, balance, sleep quality, and classroom performance;

• A student athlete will not be allowed to return to a game or practice until cleared by a physician or the OPS Athletic Training Staff;

• Following a concussion, the brain needs time to heal. There is an increased likelihood for a repeat concussion if the individual returns to play before symptoms have resolved;

• In certain instances, repeat concussion can cause permanent brain damage, even death; and

• At any point following a suspected concussion, any of the following individuals reserves the right to voice concern for the safety of a student athlete and prohibit him or her from returning to play: physician, coach, student athlete, athletic trainer, parent.

By signing below, I understand the importance of the statements above and have asked any, and all questions regarding the above statements. I further understand that I will not be allowed to participate in OPS athletics until this form is signed by a parent/guardian.

I hereby attest that I have read, fully understand, and will abide by the above statements.

Student Athlete Name __________________________________________________________

Sport(s)____________________________________________________________________________________________________

Student Athlete Signature ________________________________________________________ Date __________________________

Parent/Guardian Signature (required) _______________________________________________ Date __________________________
### Guidelines For Concussion Management:

The Goals and Outcomes of the OPS Sports Medicine Advisory Committee on Concussion Management

<table>
<thead>
<tr>
<th>GOAL</th>
<th>GOAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>To prevent increasing the severity of the injury.</td>
<td>To prevent re-injury through proper management.</td>
</tr>
</tbody>
</table>

**Guideline**

All concussions will be assessed using guidelines established by the 2008 International Conference on Concussion in Sport.

For complete details, please see your school’s Certified Athletic Trainer.

---

**If your son or daughter has sustained a concussion:**

1. Seek medical attention (physician, ER, athletic trainer)
2. Keep them out of play
3. Tell all athletic trainers and coaches about any previous or current concussions

Source: Center for Disease Control (www.cdc.gov)

---

**BRAIN INJURIES (CONCUSSIONS) SHOULD NOT BE TAKEN LIGHTLY. ONLY THOUGH IMMEDIATE AND EARLY RECOGNITION AND PROPER MANAGEMENT, CAN WE PREVENT A POTENTIALLY LIFE ALTERING EVENT.**

---

**What to Do if You Suspect Your Child Has Suffered a Concussion**

A student athlete should be taken to the emergency (ER) department if any of the following signs or symptoms are present.

- Headaches that worsen
- Seizures
- Looks very drowsy and cannot be awakened
- Repeated vomiting
- Slurred speech
- Cannot recognize people or places
- Increasing confusion or irritability
- Weakness or numbness in arms or legs
- Neck pain
- Unusual behavior change
- Any loss of consciousness
- Any symptoms that worsen or do not improve over time
- Increase in the number of symptoms
- Symptoms which begin to interfere with the student’s daily activities

---

**Resources for information on concussions and this policy may be found:**

1. Center for Disease Control [www.cdc.gov](http://www.cdc.gov)
2. Omaha Public Schools website [www.ops.org](http://www.ops.org)
4. National Federation of State High Schools Association [www.nfhs.org](http://www.nfhs.org)
Omaha Public Schools Sports Medicine Advisory Committee
Parent and Student Athlete Concussion Information
and Fact Sheet

In the fall of 2008, the Certified Athletic Trainers and Physicians working with OPS began utilizing new guidelines to evaluate, assess, and manage concussions incurred by OPS student athletes. Since then the guidelines have been reviewed and updated annually to reflect emerging best practices in the recognition and management of concussions in youth sports.

Did You Know?

According to the Center for Disease Control and other publications:

- Each year 300,000 athletes suffer sports-related concussions.
- The national estimate for concussions in high school athletes is 136,000.
- In ages 15-24, sports are the 2nd leading cause of traumatic brain injury.
- Most studies done on concussions focus on the “mature” brain and thus, we cannot ignore the fact that the young brain is still developing and the effects of concussions are not fully understood.
- High school athletes who sustain a concussion demonstrate prolonged memory dysfunction compared with college athletes.
- A concussion is: “getting your bell rung,” and “getting dinged.”
- Failure to recognize and properly manage a concussion can lead to a catastrophic injury known as “second impact syndrome.”
- Second impact syndrome can be catastrophic, even fatal.
- Second impact syndrome is preventable – if concussions are recognized and properly managed.
- On April 18, 2011, LB 260 – “The Concussion Awareness Act” was signed into law with the intent to protect the youth participating in athletics across the state from the dangers of concussions that are often unrecognized, undiagnosed, and/or mismanaged.

Sources:


According to a study by McCrea published in 2004, The top reasons for athletes not reporting concussions were:

1. Didn’t think the concussion was serious.
2. Didn’t want to leave the game.
3. Didn’t realize a concussion was sustained.
4. Didn’t want to let down their teammates.

Concussions may result from sudden trauma, such as sports injuries, that cause the brain to hit the inside of the skull.

WHAT DOES A CONCUSSION LOOK LIKE?

<table>
<thead>
<tr>
<th>SIGNS:</th>
<th>SYMPTOMS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Appears dazed or stunned</td>
<td>1. Headache or “pressure” in the head</td>
</tr>
<tr>
<td>2. Is confused about an assignment</td>
<td>2. Nausea</td>
</tr>
<tr>
<td>3. Forgets plays</td>
<td>3. Balance problems or dizziness</td>
</tr>
<tr>
<td>4. Moves clumsily or displays problems</td>
<td>4. Double or fuzzy vision</td>
</tr>
<tr>
<td>with balance and coordination</td>
<td>5. Sensitivity to light or noise</td>
</tr>
<tr>
<td>5. Loses consciousness (even briefly)</td>
<td>6. Feeling slowed down, foggy, or groggy</td>
</tr>
<tr>
<td>6. Shows behavioral of personality changes</td>
<td>7. Does not “feel right”</td>
</tr>
</tbody>
</table>