

Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a “ding” or a bump on the head can be serious. You can’t see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

What can happen if my child keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often fail to report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents and students is the key to student-athlete’s safety.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. IHSA Policy requires athletes to provide their school with written clearance from either a physician licensed to practice medicine in all its branches or a certified athletic trainer working in conjunction with a physician licensed to practice medicine in all its branches prior to returning to play or practice following a concussion or after being removed from an interscholastic contest due to a possible head injury or concussion and not cleared to return to that same contest. In accordance with state law, all IHSA member schools are required to follow this policy. You should also inform your child’s coach if you think that your child may have a concussion. Remember it’s better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to: <http://www.cdc.gov/ConcussionInYouthSports/>

Student-Athlete name (printed)

X _____
Student-Athlete signature

Parent/Guardian name (printed)

X _____
Parent/Guardian signature

Adapted from the CDC and the 3rd International Conference on Concussion in Sport

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STEROID TESTING CONSENT (HIGH SCHOOL ATHLETES ONLY)

By signing below, we consent to random testing in accordance with the IHSA's steroid testing policy. We understand that, if the student or the student's team participates in state series competitions, the student may be subject to testing for banned substances.

No student-athlete may participate in IHSA state series competition unless the student and the student's parent/guardian consent to random testing.

Parent/Guardian Signature X _____ (HIGH SCHOOL ATHLETES ONLY) _____

Student-Athlete Signature X _____ (HIGH SCHOOL ATHLETES ONLY) _____

Date Both Sides of Card Completed _____

MUST COMPLETE FRONT AND BACK OF THIS FORM & RETURN TO ATHLETIC OFFICE

(X) REQUIRED SIGNATURES

Document Created 1/17/14

SPORT: _____

YR. IN SCHOOL: 7th 8th

D300 ATHLETIC PARTICIPATION CARD

NAME: (Last) _____ (First) _____ BIRTH DATE _____ ID # _____

PARENT/GUARDIAN NAME _____ HOME # _____ CELL # _____

ADDRESS _____ PARENT/GUARDIAN EMAIL _____

I hereby give permission for my son/daughter to participate in District 300 Interscholastic Activities. I am aware that participation in sports or activities may involve risks of injury. I understand he/she must abide by the Co-Curricular Code of Conduct.

(signature of Parent/Guardian)X _____

I am aware that participation in the above sport or activity may involve risks of injury. I agree to abide by the District 300 Co-Curricular Code of Conduct.

(signature of Student-Athlete)X _____

ELECTRONIC COMMUNICATION PERMISSION FORM

My student's teacher(s)/coach(es)/co-curricular sponsor(s) have permission to communicate with my child outside normal school hours about matters pertaining to school-related academics, athletics and/or extracurricular activities. Such electronic communication, if necessary, will utilize approved e-mail or websites linked to the d300.org domain or may occur via cell phone calls and text messages (messaging rates may apply). Pursuant to district policy, electronic communications between staff and students will not be social in nature. At any time, I understand I may withhold or retract this consent as it pertains to a specific employee by contacting the principal of the school.

Parent Signature X _____

OFFICE USE ONLY

SPORT: _____

Grade Eligibility: YES NO

Athletic Obligation: NO YES

Date of Physical: _____

Paid Fee: YES NO

MUST COMPLETE ** MUST COMPLETE ** MUST COMPLETE ** MUST COMPLETE

ATHLETIC EMERGENCY MEDICAL AUTHORIZATION & MEDICAL CONSENT FOR TREATMENT

In case of emergency, attempt to contact a parent at home or at work. If we cannot be reached, attempt to contact the alternate listed below.

Alternate Name _____

Phone Number _____ Relationship _____

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examinations and immunizations for the above named student. In the event of an emergency arising out of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above named student may be given. Permission is also granted to the athletic trainer to provide the needed emergency treatment to the athlete prior to his/her admission to the medical facilities.

The athletic staff (team physicians, athletic trainers, coaches or other school personnel) may apply appropriate treatments within their realm of knowledge or training for injuries sustained during participation in interscholastic athletics sanctioned by District 300.

Comments/medical concerns or allergies the D300 staff need to be made aware of:

Signature of Parent/Guardian X _____

Cell Phone _____ Work Phone _____