2022-2023
DIAA ATHLETIC PHYSICAL AND CONSENT FORMS

Upon publication of this packet, these forms MUST be utilized when completing required DIAA forms for athletic participation. Each year, the DIAA will utilize this cover letter to update providers on any important changes and important dates.

The DIAA Sports Medicine Advisory Committee recommends that the required forms be completed by the student athlete’s primary care provider (medical home) to ensure continuity of medical care. These forms must be completed after April 1st each year based on a physical performed by the signing physician within one year of the date of signature.

**Important Information:**

- Please refer to COVID information from Center for Disease Control and Prevention (CDC) and Delaware Department of Public Health (DPH) for latest health and safety information.

- On the history form (page 3), all questions should be answered based on complete medical history (not just in the last year).

- On the physical form (page 4), a section for date of clearance has been added next to the “signature of health care professional”. The date the forms are filled out does not have to be the same day that the physical was performed. See above for timing of physical.

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Delaware Interscholastic Athletic Association
Pre-Participation Physical Evaluation/Consent Form

The DIAA pre-participation physical evaluation and consent form consists of seven pages. Pages two, three and five require a parent’s signature while pages six and seven are references for the parent and student athlete to keep. Page four requires the exam date and physician’s signature and page five requires the clearance to participate date and physician’s signature. The student must be cleared to participate on or after April 1 based on a physical examination conducted within 12 months of the signature. The clearance is valid through June 30 of the following school year unless a re-examination is required.

Name of Athlete: ___________________________ School: ___________________________
Grade: _______ Age: _______ Gender: ______ Date of Birth: _______ Phone: ________
Parent/Guardian Name: (Please Print): __________________________________________

For the physicals of 9th graders or new school enterers, please check here indicating immunization form attached: □

PARENT/GUARDIAN/STUDENT CONSENTS

____________________________________ has my permission to participate in all interscholastic sports NOT checked below
(Name of Athlete)

NOTE- If you check any sport below the athlete will NOT be permitted to participate in that sport.

<table>
<thead>
<tr>
<th>BaseBall</th>
<th>Basketball (G)(B)</th>
<th>Cross Country (G)(B)</th>
<th>Field Hockey</th>
<th>Football</th>
</tr>
</thead>
<tbody>
<tr>
<td>Golf</td>
<td>Lacrosse (G)(B)</td>
<td>Soccer (G)(B)</td>
<td>Softball</td>
<td>Swimming (G)(B)</td>
</tr>
<tr>
<td>Tennis (G)(B)</td>
<td>Track (G)(B)</td>
<td>Volleyball</td>
<td>Wrestling</td>
<td>Cheerleading</td>
</tr>
<tr>
<td>Unified Football</td>
<td>Unified Basketball</td>
<td>Unified Track</td>
<td>Other__________</td>
<td>Other__________</td>
</tr>
</tbody>
</table>

1. My permission extends to all interscholastic activities whether conducted on or off school premises. I have read and discussed the Parent/Player Concussion Information Document; Sudden Cardiac Arrest Awareness Sheet and I will retain those pages for my reference. I have also discussed with him/her and we understand that physical injury, including paralysis, coma or death and exposure to COVID-19 can occur as a result of participation in interscholastic athletics. I waive any claim for injury, illness, or damage incurred by said participant while participating in the activities NOT checked above.

Parent Signature: ___________________________ Date:____________________
Student Signature: ___________________________ Date:____________________

2. To enable DIAA and its full and associate member schools to determine whether herein named student is eligible to participate in interscholastic athletics, I hereby consent to the release of any and all portions of school record files, beginning with the sixth grade, of the herein named student, including but not limited to, birth and age records, name and residence of student’s parent(s), guardian(s) or Relative Care Giver, residence of student, health records, academic work completed, grades received and attendance records.

Parent Signature: ___________________________ Date:____________________

3. I further consent to DIAA and it’s full and associate member schools use of the herein named student’s name, likeness, and athletically related information in reports of interscholastic practices, scrimmages or contests, promotional literature of the association, and other materials and releases related to interscholastic athletics.

Parent Signature: ___________________________ Date:____________________

4. By this signature, I hereby consent to allow the physician(s) and other health care provider(s) selected by myself or the schools to perform a pre-participation examination on my child and to provide treatment for any injury received while participating in or training for athletics for his/her school. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation, with coaches, medical staff, Delaware Interscholastic Athletic Association, and other school personnel as deemed necessary. Such information may be used for injury surveillance purposes.

Parent Signature: ___________________________ Date:____________________

5. By this signature, I agree to notify the physician and school of any health changes during the school year that could impact participation in interscholastic athletics.

Parent Signature: ___________________________ Date:____________________
**HISTORY FORM** *Form completed annually along with a Consent & Medical Card. Athlete and parent should fill out form prior to visit.*

Name: ___________________________ Age: ______________ Date of Birth: ______________ Grade: ____________

Sex: ___________ School: ___________________________ Sport(s): ___________________________

**List past and current medical conditions:**

**List all current prescriptions, otc medicines, and supplements (herbal & nutritional):**

**List of all your allergies (medicines, pollens, food, stinging insects etc):**

**General Questions**

1. Do you have any concerns you would like to discuss with your provider?

2. Has a provider ever denied or restricted your participation in sports for any reason?

3. Do you have any medical issues or recent illness?

**Heart Health Questions About You:**

4. Have you ever passed out or nearly passed out during or after exercise?

5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?

6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?

7. Has a doctor told you that you have any heart issues?

8. Has a doctor ever requested a test for your heart? For example, electrocardiogram (EKG) or echocardiogram?

9. Do you get light headed or feel short of breath more than your friends, during exercise?

10. Have you ever had a seizure?

**Heart Health Questions About Your Family**

11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?

12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?

13. Has anyone in your family had a pacemaker, or implanted defibrillator before age 35?

**Bone and Joint Questions**

14. Since you were last cleared to play sports, have you had a new injury to a bone, muscle, ligament or tendon?

**Medical Questions**

15. Have you been diagnosed with COVID-19?

16. Do you cough, wheeze, or have difficulty breathing during or after exercise?

17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?

18. Do you have groin or testicle pain or a painful burple 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 problem?

21. Have you ever had numbness, tingling, 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 during exercising in the heat?

23. Do you or someone in your family have sickle cell trait or disease?

24. Have you ever had or do you have problems with your eyes or vision?

25. Do you worry much about your weight?

26. Are you trying or has anyone recommended you gain or lose weight?

27. Are you on a special diet or do you avoid certain types of foods or food groups?

28. Have you ever had an eating disorder?

29. Have you ever been told by a doctor you have any heart issues?

30. Has a doctor ever requested a test for your heart? For example, electrocardiogram (EKG) or echocardiogram?

31. Answer “Yes” if ever occurred. Explain “yes” answers here:

   20. Have you ever had a concussion or head injury that caused confusion, a prolonged headache, or memory problem?

   21. Have you ever had numbness, tingling, weakness in your arms or legs or been unable to move your arms or legs after being hit or falling?

   22. Have you ever become ill during exercising in the heat?

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25. Do you worry much about your weight?

26. Are you trying or has anyone recommended you gain or lose weight?

27. Are you on a special diet or do you avoid certain types of foods or food groups?

28. Have you ever had an eating disorder?

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

Signature of Athlete: ___________________________ Date: ________________

Signature Parent/Guardian: ___________________________ Date: ________________

Rev 3/29/22 updated
**PHYSICAL EXAMINATION FORM**

Name __________________________________________ Date of Birth ____________________________

**PHYSICIAN REMINDERS**
1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - 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)

<table>
<thead>
<tr>
<th>EXAMINATION</th>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>/</td>
<td>/</td>
</tr>
</tbody>
</table>

**MEDICAL**
- Appearance
  - Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse MVP, aortic insufficiency)
- Eyes/ears/nose/throat
  - Pupils equal
  - Hearing
- Lymph nodes
- Heart
  - Murmurs (auscultation standing, supine, +/- Valsalva)
- Lungs
- Abdomen
- Skin
  - Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis
- Neurological
- MUSCULOSKELETAL
  - Neck
  - Back
  - Shoulder and arm
  - Elbow and forearm
  - Wrist, hand, and fingers
  - Hip and thigh
  - Knee
  - Leg and ankle
  - Foot and toes
  - Functional
    - Double-leg squat test, single-leg squat test, and box drop or step drop test

*Consider ECG, echocardiogram, echocardiography, referral to cardiologist for abnormal cardiac history or examination findings, or a combination of these.


**Comments:**

Name of HealthCare Professional (MD/DO,NP,PA) print or type: __________________________________________ Date of Exam: ____________________________

Address: __________________________________________ Phone: __________________________

Signature of HealthCare Professional: __________________________ Date of Clearance: __________________________

**Please sign pages four and five of the pre-participation packet**

SCHOOL ATHLETE MEDICAL CARD *
(Parent/Guardian: Please complete Sections 1, 2 & 3. Please print.)

**Section 1: Contact / Personal Information**

Name: ___________________________ Sport(s): ___________________________
Age: _______ Birthdate: _______ School: ___________________________ Grade: _______
Guardian Name: ___________________________
Address: ___________________________
Phone: (H) __________________ (W): __________________ (C): __________________ (P): __________
Other Authorized Person To Contact In Case Of Emergency:
Name: ___________________________ Phone(s): ___________________________
Name: ___________________________ Phone(s): ___________________________
Preference Of Physician (And Permission To Contact If Needed):
Name: ___________________________ Phone: ___________________________
Hospital Preference: ___________________________ Insurance: ___________________________
Policy #: __________________ Group: __________ Phone: __________

**Section 2: Medical Information**

Medical Illnesses: ___________________________
Last Tetanus (Mo/Yr): _______ Allergies: ___________________________ Braces/Splints: ___________________________
Medications: ___________________________
(Any medication(s) that may need to be taken during competition require a physician’s note.)
Previous Head/Neck/Back Injury: ___________________________
Heat Disorder, Or Sickle Cell Trait: ___________________________
Previous Significant Injuries: ___________________________
Any Other Important Medical Information:

**Section 3: Consent for Athletic Conditioning, Training and Health Care Procedures**

I hereby give consent for my child to participate in the school’s athletic conditioning and training program, and to receive any necessary healthcare treatment including first aid, diagnostic procedures, and medical treatment, that may be provided by the treating physicians, nurses, athletic trainers, or other healthcare providers employed directly or through a contract by the school, or the opposing team’s school. The healthcare providers have my permission to release my child’s medical information to other healthcare practitioners and school officials. In the event I cannot be reached in an emergency I give permission for my child to be transported to receive necessary treatment. I understand that Delaware Interscholastic Athletic Association or its associates may request information regarding the athlete’s health status, and I hereby give my permission for the release of this information as long as the information does not personally identify my child.

Parent/Guardian Signature: ___________________________ Date: ____________
Athlete’s Signature: ___________________________ Date: ____________

**Section 4: Clearance for Participation**

_____ Not Cleared _____ Cleared without restrictions ____ Cleared with the following restrictions: ___________________________

Health Care Provider’s Signature: ___________________________ MD/DO, PA, NP Date: ____________

If this form is being completed as part of the supplemental form, then a physician signature is not needed until a new physical is performed.

For School Office Use Only: This card is valid from April 1, 20________ through June 30, 20________

Note: If any changes occur, a new card should be completed by the parent/guardian. The original card should be kept on file in the school nurse, athletic director’s or athletic trainer’s office. A copy should be kept in the sports’ athletic kit. This card contains personal medical information and should be treated as confidential by the school, its employees, agents, and contractors.

Name of School: __________________________________________ Name of School QHP: __________________________________

Rev 3/29/22 updated
Delaware Interscholastic Athletic Association
Parent/Player Concussion Information Document

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.

Symptoms may include one or more of the following:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Symptom</th>
<th>Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headaches</td>
<td>Pressure in head</td>
<td>Nausea or vomiting</td>
</tr>
<tr>
<td>Neck pain</td>
<td>Balance problems</td>
<td>Dizziness</td>
</tr>
<tr>
<td>Disturbed vision</td>
<td>Light/noise sensitivity</td>
<td>Sluggish</td>
</tr>
<tr>
<td>Feeling foggy</td>
<td>Drowsiness</td>
<td>Changes in sleep</td>
</tr>
<tr>
<td>Amnesia</td>
<td>“Don’t feel right”</td>
<td>Low energy</td>
</tr>
<tr>
<td>Sadness</td>
<td>Nervousness</td>
<td>Irritability</td>
</tr>
<tr>
<td>Confusion</td>
<td>Repeating questions</td>
<td>Concentration problems</td>
</tr>
</tbody>
</table>

Signs observed by teammates, parents, and coaches may include:

<table>
<thead>
<tr>
<th>Sign</th>
<th>Sign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appears dazed</td>
<td>Vacant facial expression</td>
</tr>
<tr>
<td>Confused about assignment</td>
<td>Forgets plays</td>
</tr>
<tr>
<td>Unsure of game/score etc</td>
<td>Clumsy</td>
</tr>
<tr>
<td>Responds slowly</td>
<td>Personality changes</td>
</tr>
<tr>
<td>Seizures</td>
<td>Behavior changes</td>
</tr>
<tr>
<td>Loss of consciousness</td>
<td>Uncoordinated</td>
</tr>
<tr>
<td>Can’t recall events before or after hit</td>
<td></td>
</tr>
</tbody>
</table>

What can happen if my child keeps on playing with a concussion or returns to 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 (second impact syndrome). This can lead to prolonged recovery, or even to severe brain swelling with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often under report symptoms of injuries, and concussions are no different. As a result, education of administrators, coaches, parents and students is the key for the 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. You should also inform your child's coach if you think that your child may have a concussion. Remember it is 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 from the CDC on concussions you can go to:

http://www.cdc.gov/headsup/youthsports/index.html

For a current update of DIAA policies and procedures on concussions you can go to:

https://education.delaware.gov/diaa/health_and_safety/concussions_and_sudden_cardiac_arrest/

For a free online training video on concussions you can go to:

https://nfhslearn.com/courses?searchText=Concussion

All parents and players must sign the signature portion of the PPE indicating they have read and understand the above.
**Sudden Cardiac Arrest Awareness Sheet**

### What is Sudden Cardiac Arrest?
- An electrical malfunction (short-circuit) causes the bottom chambers of the heart (ventricles) to beat dangerously fast (ventricular tachycardia or fibrillation) and disrupts the pumping ability of the heart.
- Occurs suddenly and often without warning.
- The heart cannot pump blood to the brain, lungs and other organs of the body.
- The person loses consciousness (passes out) and has no pulse.
- Death occurs within minutes if not treated.

### What causes Sudden Cardiac Arrest?
- Conditions present at birth (inherited and non-inherited heart abnormalities)
- A blow to the chest (Commotio Cordis)
- An infection/inflammation of the heart, usually caused by a virus. (Myocarditis)
- Recreational/Performance-Enhancing drug use.
- Other cardiac & medical conditions/Unknown causes. (Obesity/Idiopathic)

### What are the symptoms/warning signs of Sudden Cardiac Arrest?
- Fainting/blackouts (especially during exercise)
- Dizziness
- Unusual fatigue/weakness
- Chest pain
- Shortness of breath
- Nausea/vomiting
- Palpitations (heart is beating unusually fast or skipping beats)
- Family history of sudden cardiac arrest at age < 50
  
  ANY of these symptoms/warning signs may necessitate further evaluation from your physician before returning to practice or a game.

### What are ways to screen for Sudden Cardiac Arrest?
- The American Heart Association recommends a pre-participation history and physical including 12 important cardiac elements.
- **The DIAA Pre-Participation Physical Evaluation – Medical History** form includes ALL 12 of these important cardiac elements and is mandatory annually. Please answer the heart history questions on the student health history section of the DIAA PPE carefully.
- Additional screening using an electrocardiogram and/or an echocardiogram is readily available to all athletes, but is not mandatory.

### Where can one find additional information?
- Contact your primary care physician
- American Heart Association ([www.heart.org](http://www.heart.org))
- August Heart ([www.augustheart.org](http://www.augustheart.org))
- Championship Hearts Foundation ([www.champhearts.org](http://www.champhearts.org))
- Parent Heart Watch ([www.parentheartwatch.com](http://www.parentheartwatch.com))
- NFHS Learn Center – Sudden Cardiac Arrest Video ([www.nfhslearn.com](http://www.nfhslearn.com))

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