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.

Key Changes:

- Please refer to updated COVID information sheets and regulations 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.
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
____________________________________________________________________________________
(Name of Athlete)

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

Baseball Basketball (G)(B) Cross Country (G)(B) Field Hockey Football
Golf Lacrosse (G)(B) Soccer (G)(B) Softball Swimming (G)(B)
Tennis (G)(B) Track (G)(B) Volleyball Wrestling Cheerleading
Unified Football Unified Basketball Unified Track Other__________________ Other__________________

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: ____________________________

Rev 3/3/22
**HISTORY FORM** *(Form completed annually along with a Consent & Medical Card. Athlete and parent should fill out form prior to visit.)*

<table>
<thead>
<tr>
<th>Name: ____________________________</th>
<th>Age: ____________</th>
<th>Date of Birth: ____________</th>
<th>Grade: ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex: ____________________________</td>
<td>School: ____________________________</td>
<td>Sport(s): ____________________________</td>
<td></td>
</tr>
</tbody>
</table>

**List past and current medical conditions:**

<table>
<thead>
<tr>
<th>Have you ever had surgery? If yes list all past surgical procedures:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

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

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

| Over the past 2 weeks, how often have you been bothered by any of the following (circle): |
|-----------------------------------------------|---------------------------------|-----------------|-----------------|-----------------|-----------------|
| Feeling nervous, anxious, or on edge | Not at all | Several days | Over half the days | Nearly every day |
| 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 |

Mental Health: A sum of >= 3 for questions 1+2, or 3+4, is considered positive.

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**General Questions**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have any concerns you would like to discuss with your provider?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Has a provider ever denied or restricted your participation in sports for any reason?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you have any medical issues or recent illness?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Heart Health Questions About You:**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Have you ever passed out or nearly passed out during or after exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Has a doctor told you that you have any heart issues?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Has a doctor ever requested a test for your heart? For example, electrocardiogram (EKG) or echocardiogram?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Do you get light headed or feel shorter of breath more than your friends during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Have you ever had a seizure?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Heart Health Questions About Your Family**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Has anyone in your family had a pacemaker, or implanted defibrillator before age 35?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Bone and Joint Questions**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Since you were last cleared to play sports, have you had a new injury to a bone, muscle, ligament or tendon?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Medical Questions**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. Have you been diagnosed with COVID-19?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Do you cough, wheeze, or have difficulty breathing during or after exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Do you have groin, or testicle pain or a painful bulge or hernia in the groin area?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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SCHOOL QUALIFIED HEALTHCARE PROFESSIONAL: (RN/AT)

If “Yes” is answered to any of the above, or “3+” for mental health questions, since the athlete was last cleared for athletic participation, a referral and clearance by the athlete’s primary care provider is required.

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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 3/3/22
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>Weight</th>
<th>BP ( )/ ( )</th>
<th>Pulse</th>
<th>Vision R 20/ L 20/ Corrected</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
</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**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Sport(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td>Birthdate: _______</td>
</tr>
<tr>
<td>School:</td>
<td>Grade: _______</td>
</tr>
<tr>
<td>Guardian Name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Phone: (H)</td>
<td>(W)</td>
</tr>
<tr>
<td>Other Authorized Person To Contact In Case Of Emergency:</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td>(C):</td>
</tr>
<tr>
<td>Preference Of Physician (And Permission To Contact If Needed):</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td>(P):</td>
</tr>
</tbody>
</table>

**Section 2: Medical Information**

| Medical Illnesses:                                   |
|-----------------|--------------------|
| Last Tetanus (Mo/Yr): ______ | Allergies: _______ |
| Medications:   | Braces/Splints:   |
| (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:                       |

**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 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**

<table>
<thead>
<tr>
<th>Not Cleared</th>
<th>Cleared without restrictions</th>
<th>Cleared with the following restrictions:</th>
</tr>
</thead>
</table>

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: ___________________________
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:**

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

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

- Appears dazed
- Vacant facial expression
- Confused about assignment
- Forgets plays
- Unsure of game/score etc
- Clumsy
- Responds slowly
- Personality changes
- Seizures
- Behavior changes
- Loss of consciousness
- Uncoordinated
- Can’t recall events before or after hit

**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:  

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/](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:  

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

Adapted from the KHSAA, CDC and 3rd International Conference on Concussion in Sport, 4/2011
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)
- August Heart (www.augusttheheart.org)
- Championship Hearts Foundation (www.champhears.org)
- Cody Stephens Foundation (www.codystephensfoundation.org/)
- Parent Heart Watch (www.parentheartwatch.com)
- NFHS Learn Center – Sudden Cardiac Arrest Video (www.nfhslearn.com)

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