



**LOS ANGELES UNIFIED SCHOOL DISTRICT  
POLICY BULLETIN**

**TITLE:** Medical Clearance and Return to Play Guidelines for Students Participating in Interscholastic Athletics and Select Auxiliary Units

**NUMBER:** BUL-4948.2

**ISSUER:** Dr. Debra Duardo, Executive Director  
Student Health and Human Services

Dr. Thelma Meléndez de Santa Ana  
Chief Executive Officer  
Office of Educational Services

**ROUTING**  
LD Superintendents  
Administrators of Operations  
Principals  
Assistant Principals  
School Nurses  
School Physicians  
Athletic Directors  
Coaches

**DATE:** January 4, 2016

**POLICY:** Each student planning to participate in California Interscholastic Athletic Federation competition or cheerleading must undergo an annual Pre-participation Physical Evaluation by a qualified California licensed health care provider prior to participation in any aspect of the competition, including tryouts and practices. Select auxiliary units and marching band must undergo a physical evaluation, at least once prior to tryout, practice and participation. If a licensed health care provider determines that the athlete sustained a concussion or a head injury, the athlete is required to complete a graduated return to play protocol of no less than 7 days in duration under the supervision of a licensed health care provider.

**MAJOR CHANGES:** This Bulletin replaces BUL-4948.1 titled “Pre-participation Physical Evaluation and Medical Clearance of Students Participating in Interscholastic Athletics and Select Auxiliary Units,” dated October 1, 2010. The content has been updated to reflect new policy on concussion and return to play guidelines, as well as current requirements, personnel, and phone numbers to call for assistance.

**GUIDELINES:** I. PHYSICAL EXAMINATION FOR INTERSCHOLASTIC ATHLETICS

A. Goals and Objectives

The overall goal of the Pre-participation Physical Evaluation (PPE) is to help maintain the health and safety of the athlete in training and competition which is achieved by three primary objectives:

- Detect conditions that may be life threatening or disabling
- Detect conditions that may predispose to injury
- Meet legal and administrative requirements

The goal of following the graduated return to play guidelines after head injuries, such as concussion, is to prevent sequelae such as second impact syndrome, post-concussion syndrome, and permanent neurologic deficits. It also meets legal and administrative requirements.



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### B. Qualification of the Examiners

Qualification of an examiner to perform the PPE is based on training and clinical expertise. In general, the District accepts medical clearance from California-licensed health care providers in the following groups:

- Physician (MD/DO)
- Nurse Practitioner (NP)
- Physician Assistant (PA)

Nurse practitioners and physician assistants that are appropriately trained and licensed may perform PPEs under the direct or indirect supervision of a California-licensed physician. Co-signatures are not required by law, and therefore should not be required on PPE forms. However, the School Nurse should be able to contact the health care provider to clarify a clearance or recommendation in order to ensure the health and safety of the athlete.

Only a California- licensed health care provider trained in the management of concussions and acting within the scope of his or her practice should evaluate a suspected concussion and clear the student for return to athletic activity. The California Interscholastic Federation recommends a physician (MD/DO) evaluation and clearance of concussions.

All providers should work within the scope of their license and use appropriate referral and consultation to address problems beyond their expertise.

### C. Timing and Frequency of the Evaluation

A full PPE must be conducted annually prior to participation in any aspect of the competition, including tryouts and practices. To allow for time to treat or rehabilitate any identified problem, the PPE should ideally be performed at least 6 weeks prior to the start of practice. To avoid potential difficulties of scheduling evaluations in mid-summer during conditioning or pre-season practice, evaluations may be performed at the end of the previous school year.

Evaluation of a suspected concussion is an acute medical issue and steps should be taken to receive an evaluation by a qualified health care provider. Emergency medical services may need to be called. Parents/guardians should be informed immediately, including the completion of a *Concussion Injury Report* (Attachment C) and a *Confidential Athletic Injury Tracking Form* (Attachment E).

### D. Methods and Settings of the Evaluation

The best setting for a full PPE is in the primary care provider's office. Students should be encouraged to plan in advance and schedule a visit to



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their provider for a PPE well before the start of the season. Students and parents/guardians should be provided the forms that need to be completed for medical clearance (Attachment A).

While the PPE is not intended to substitute for an athlete's routine health maintenance/physical examination, PPE offers an opportunity for the provider to provide general health maintenance and counseling on health-related issues and could be an added benefit to the athlete, if time and circumstances permit.

Mass screenings in a gym or auditorium are generally not sufficient to accomplish the objectives of the PPE (see above). There are some instances where a qualified medical team can be assembled to provide a thorough and confidential evaluation of many athletes in a shorter period of time. However, schools should be cautioned that an "assembly line" approach may miss serious problems in an athlete that can lead to injury or death, and the qualified examiner (see I.B.) is responsible for examining the student and ultimately determining clearance for athletic participation.

Volunteer health care providers doing athletic physical examinations without charge, in schools, must comply with LAUSD volunteer guidelines and the California State Education Code. A fee may not be charged for physical examinations done on school sites without the appropriate permit or lease from the Real Estate Branch. For further information, please see [BUL-1559, "Delivery of Volunteer Health and Mental Health Services to Students," dated January 6, 2005.](#)

### E. Forms for Documenting Evaluation and Injury

The full PPE should be documented on the *Pre-participation Physical Evaluation* form (Attachment A). The form includes health history, physical exam, and clearance sections, which are important for documentation of a full PPE. The California Interscholastic Federation Sports Medicine Committee recommends the use of the PPE form published in the *Pre-participation Physical Evaluation, 4<sup>th</sup> Edition* (see references). Attachment A is adapted from the monograph and is the preferred form for documenting evaluation and clearance. School personnel should use reasonable judgment when accepting PPEs documented on alternative medical clearance forms; any other PPE accepted must include a statement that the student has been cleared for (competitive) sports. Any questions about the PPE form should be directed to the School Nurse.

The *Confidential Athletic Injury Tracking Form* (Attachment E) replaces other injury tracking forms and is used to document injuries sustained during competition, practice or tryouts. The *\*Concussion Injury Report* (Attachment C) should be completed at the time of the injury and a copy of



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the form should be distributed to appropriate parties (e.g., Athletic Directors, Parents/Guardians, School Nurse, or Administrator). The *\*\*Concussion Return to Play (RTP) Protocol* (Attachment D) is to be used as the graduated return to play protocol following concussion and clearance from a licensed health care provider.

\* The official triplicate *Concussion Injury Report* form must be utilized.

\*\**Concussion Return to Play (RTP) Protocol* is on back of the *Concussion Injury Report*.

This form is available to order through Reprographics Unit.

## II. PROCEDURES AND RESPONSIBILITIES

### A. Athletic Director and Coaches

1. Distribute the following to students planning to try out for competitive athletics:
  - a. Athletic Record Card to be completed and signed on the back by the student and the parent/guardian. Personal identifying information on the face of the card should be completed by the student.
  - b. The *Pre-participation Physical Evaluation* form is to be completed and signed by a California-licensed health care provider with the contact information of the clinic or office where it was performed.
2. After removing the Insurance Certificate, take the completed Athletic Record Card and the completed *Pre-participation Physical Evaluation* form to the School Nurse. Medical clearance is valid for one year only.
3. File the Insurance Certificate with the Athletic Director.
4. Keep a record of students who have been medically approved, deferred, or disapproved.
5. In the event of an injury during competition, practice or tryout, complete the *Confidential Athletic Injury Tracking Form* (Attachment E), or have the appropriate medical attendant complete the form.
6. If the athlete is suspected of sustaining a concussion or head injury, complete the *Concussion Injury Report* (Attachment C). Communicate with the parent or guardian, as indicated, including providing a copy of the *Concussion Injury Report*. Have the parent/guardian sign and take a copy of the *Concussion Injury Report* and *Concussion Return to Play (RTP) Protocol* to their health care provider for signature, clearance and recommendations for return to play.
7. Forward any copies of completed *Concussion Injury Reports* or recommendations/clearances from licensed health care providers for a return to play protocol to the School Nurse for verification.

### B. School Nurse

1. Evaluate PPE, health history and review the Welligent student health record, as well as any hard copy record, if available.



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2. Determine whether the health care provider's approval is in accord with what is documented on the PPE (Attachment A). If necessary, contact the health care provider to clarify any recommendation or restriction. If, after contacting the private health care provider, there are unresolved questions regarding the clearance, consult with the local district school physician.
3. File the completed PPE with the student's health record in the school Health Office.
4. If a student sustains an injury, review the *Confidential Athletic Injury Tracking Form* or iSTAR report that has been filed.
5. If the student sustains or is suspected of a concussion, review the *Concussion Injury Report* and clearance/recommendation by a licensed health care provider to begin a graduated return to play protocol. The School Nurse should verify the clearance by the student's health care provider and document/sign on the *Concussion Return to Play Protocol* (Attachment D).
6. Communicate with the staff (Athletic Director, coach, athletic trainer) regarding the RTP status for the student.

### III. DETERMINING CLEARANCE FOR ATHLETIC PARTICIPATION

The most important decision in the PPE is determining clearance for athletic participation. Clearance can be divided into four categories:

- Clearance without restriction.
- Clearance with recommendation for further evaluation or treatment (such as rechecking blood pressure in one month).
- "Not cleared" clearance status to be reconsidered after completion of further evaluation, treatment or rehabilitation.
- Not cleared for certain types of sports or for all sports.

If the athlete cannot play the sport of choice, the health care provider should consider alternatives that allow some form of participation.

It is extremely important to ensure complete understanding by the athletes, parents, coaches and, when necessary, school administrators of any restrictions, necessary follow-up and treatment, and any alternative activities in which the athlete may participate. To respect confidentiality, school district personnel should be cautious about how and with whom they share the student's personal protected health information. Information should only be shared with LAUSD staff members who are involved with the student's athletic participation.

The *Pre-participation Physical Evaluation* 4<sup>th</sup> Edition has a discussion of the categories of possible disqualifying issues. For most chronic health conditions, the evidence supports and encourages the participation of children and adolescents in athletic activities. A summary of medical conditions and sports



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participation is included in Attachment B. Most conditions in the table have a “yes” or “qualified yes” with regards to participation in athletics. While this table may assist medical and nonmedical personnel in determining appropriate sports participation decisions, it should never substitute for sound medical judgment and consideration of all variables known to influence safe and healthy athletic activity.

It should be noted that LAUSD has a separate policy for functionally one-eyed athletes. See “[Clearance Policy for Student Athletes with Impaired Vision](#),” which can be found in LAUSD’s e-library.

## IV. RETURN TO ATHLETIC PARTICIPATION

### A. Minor Illness or Injury

A student absent from athletic practice or competition for an extended period of time due to illness or injury must present a written statement from the treating California-licensed health care provider indicating a recommendation for return to athletic participation and any modifications or accommodations that may need to be implemented. The student shall be referred to the School Nurse who will determine eligibility and notify the coach.

### B. Serious Illness or Injury

Any student who sustains a serious injury in an athletic competition, practice, or tryout should be immediately evaluated by the appropriate medical personnel. Serious injury or illness includes, but is not limited to, concussion, fracture, ruptured kidney, spleen or liver, extensive lacerations, torn ligaments, etc. A *Confidential Athletic Injury Tracking Form* (Attachment E) should be completed by the coach or medical attendant. Other forms used for communication with the parent or guardian, health care personnel, and appropriate school personnel are described above. The student returning with written approval from the California-licensed health care provider following a serious injury must be referred to the School Nurse for reevaluation prior to resuming practice and competitive athletics. A student who sustained a concussion or has symptoms of a concussion, cannot return to play the same day of the injury, must be evaluated by a licensed health care provider, and complete a graduated return to play protocol no less than 7 days from the date of diagnosis (Attachment D).

## V. HEALTH CLEARANCE FOR CHEERLEADERS

Although AB 949, the California law that recognizes cheerleading as a competitive sport regulated by the California Interscholastic Federation (C.I.F.) does not mandate PPE for cheerleaders until the 2018-19 school year, LAUSD recognizes that these activities often include strenuous activities or skills that warrant a pre-participation physical evaluation.



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Students who wish to participate in cheerleading will obtain a PPE annually prior to tryout, practice and competition. The coach or instructor shall distribute the necessary forms, and the School Nurse shall collect and review the forms as described in section II.B.

## VI. HEALTH CLEARANCE FOR AUXILIARY UNITS (DRILL TEAM, FLAG TEAM, AND DANCE TEAM) AND MARCHING BAND

Students who wish to participate in select auxiliary units and marching band activities will obtain a PPE at least once prior to tryout, practice and competition. The coach or instructor shall distribute the necessary forms, and the School Nurse shall collect and review the forms as described in section II.B. Annual physical clearances are not required, but the students, their families and coaches should report any interim health issue that will affect participation to the School Nurse. The School Nurse should screen the Student Health Record each year to determine District clearance to participate.

**AUTHORITY:** This is a policy of the Los Angeles Unified School District, Student Health and Human Services and Interscholastic Athletics Department.

- California Interscholastic Federation: CIF Bylaw 503.G and 503.H
- California Education Code § 49475 and 35179.5

### RELATED

### ATTACHMENTS:

### RESOURCES:

- A – Pre-Participation Physical Evaluation (English and Spanish)
- B – Medical Conditions and Sports Participation
- C – Concussion Injury Report (English/Spanish)
- D – Concussion Return to Play (RTP) Protocol
- E – Confidential Athletic Injury Tracking Form

- American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Pre-participation Physical Evaluation, 4<sup>th</sup> Ed. 2010.
- Stephen G. Rice and the Council on Sports Medicine and Fitness, Medical conditions affecting sports participation, Pediatrics 2008, 121, 841-848.
- California Interscholastic Federation. Sports Medicine Handbook. 4<sup>th</sup> Ed. 2011. Accessed at: <http://www.cifstate.org>

**ASSISTANCE:** For assistance or further information, please contact Director, Student Medical Services at (213) 202-7584; or Director, District Nursing Services at (213) 202-7580; or Coordinator, Interscholastic Athletics Department at (213) 241-5847.

Date of Exam: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Personal Physician/Provider: \_\_\_\_\_

In case of emergency, contact: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Cell) \_\_\_\_\_

Medicines and Allergies: Please list all the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

Do you have any allergies?  Yes  No If yes, please identify specific allergy below.

- Medicines                       Pollens                       Food                       Stinging insects

*This section is to be carefully completed by the student and his/ her parent(s) or legal guardian(s) before participation in interscholastic athletics. Explain Yes answers below. Circle questions you don't know the answers to.*

GENERAL QUESTIONS		Yes	No	MEDICAL QUESTIONS		Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?				26. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____				27. Have you ever used an inhaler or taken asthma medicine?			
3. Have you ever spent the night in a hospital?				28. Is there anyone in your family who has asthma?			
4. Have you ever had surgery?				29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?			
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?				31. Have you had infectious mononucleosis (mono) within the last month?			
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?				32. Do you have any rashes, pressure sores, or other skin problems?			
7. Does your heart ever race or skip beats (irregular beats) during exercise?				33. Have you had a herpes or MRSA skin infection?			
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> A Heart Infection <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> A Heart Murmur <input type="checkbox"/> High Cholesterol        Other: _____				34. Have you ever had a head injury or concussion?			
9. Has a doctor ever ordered a test for your heart (for example, ECG/EKG, echocardiogram)?				35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?			
10. Do you get lightheaded or feel more short of breath than expected during exercise?				36. Do you have a history of seizure disorder?			
11. Have you ever had an unexplained seizure?				37. Do you have headaches with exercise?			
12. Do you get more tired or short of breath more quickly than your friends during exercise?				38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?			
				39. Have you ever been unable to move your arms or legs after being hit or falling?			
				40. Have you ever become ill while exercising in the heat?			
				41. Do you get frequent muscle cramps when exercising?			
HEALTH QUESTIONS ABOUT YOUR FAMILY		Yes	No	42. Do you or someone in your family have sickle cell trait or disease?			
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome?)				43. Have you had any problems with your eyes or vision?			
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?				44. Have you had any eye injuries?			
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?				45. Do you wear glasses or contact lenses?			
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?				46. Do you wear protective eyewear, such as goggles or a face shield?			
				47. Do you worry about your weight?			
				48. Are you trying to or has anyone recommended that you gain or lose weight?			
				49. Are you on a special diet or do you avoid certain types of food?			
				50. Have you ever had an eating disorder?			
BONE AND JOINT QUESTIONS		Yes	No	51. Do you have any concerns that you would like to discuss with a doctor?			
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?				FEMALES ONLY			
18. Have you had any broken or fractured bones or dislocated joints?				52. Have you ever had a menstrual period?			
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?				53. How old were you when you had your first menstrual period?			
20. Have you ever had a stress fracture?				54. How many periods have you had in the last 12 months?			
21. Have you been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)				Explain "yes" answers here:			
22. Do you regularly use a brace, orthotics or other assistive device?							
23. Do you have a bone, muscle or joint injury that bothers you?							
24. Do any of your joints become painful, swollen, feel warm, or look red?							
25. Do you have any history of juvenile arthritis or connective tissue disease?							

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

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_



# Physical Examination Form

The section below is to be completed by physician or staff after history and consent forms are completed.

ATTACHMENT A

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ %BMI (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_, ( \_\_\_\_\_ / \_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_\_ )  
 Vision: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

## EMERGENCY INFORMATION

Allergies: \_\_\_\_\_  
 Other Information: \_\_\_\_\_

MEDICAL	Normal	Abnormal Findings
Appearance ● Marfan stigmata (kyphoscoliosis, high arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ Ears/ Nose/ Throat ● Pupils equal ● Hearing		
Lymph Nodes		
Heart <sup>1</sup> ● Murmurs (auscultation standing, supine, +/- Valsalva) ● Location of point of maximal impulse (PMI)		
Lungs		
Abdomen		
Genitourinary (males only) <sup>2</sup>		
Skin ● HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic <sup>3</sup>		

## MUSCULOSKELETAL

Neck		
Back		
Shoulder/ Arm		
Elbow/ Forearm		
Wrist/ Hand/ Fingers		
Hip/ Thigh		
Knee		
Leg/ Ankle		
Foot/ Toes		
Functional ● Duck walk, single leg hop		

<sup>1</sup> Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam

<sup>2</sup> Consider GU exam if in private setting. Having 3rd party present is recommended.

<sup>3</sup> Consider cognitive evaluation or baseline neuropsychiatric setting if a history of significant concussion.

## Clearance

Cleared for all sports without restriction

Cleared for all sports without restriction with recommendations for further evaluation or treatment for: \_\_\_\_\_

Not cleared

Pending further evaluation

For any sports

For certain sports: \_\_\_\_\_

Reason/Recommendations: \_\_\_\_\_

I have evaluated the above named student and completed the pre-participation physical evaluation. The athlete does not present apparent contraindications to practice, tryout and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parent. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician/ Provider: (print/ type/ stamp) \_\_\_\_\_ (MD, DO, NP or PA) Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Physician/ Provider: \_\_\_\_\_

Modified from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine, 2010.

# Distrito Escolar Unificado de Los Angeles

## Evaluación Física Previa a la Participación

ANEXO A-1

Fecha del examen: \_\_\_\_\_

Nombre del alumno(a): _____	Sexo: _____	Edad: _____	Fecha de nacimiento: _____
Grado: _____ Escuela: _____		Deporte(s): _____	
Dirección: _____		Teléfono: _____	
Doctor o proveedor médico personal: _____			
Persona a notificar en caso de emergencia. Nombre: _____		Relación: _____	
Teléfono: (Casa) _____		(Trabajo) _____	
		(Celular) _____	

**Medicamentos y alergias:** Por favor enumere todas las medicinas y suplementos (naturales y nutritivos) con o sin receta médica que actualmente toma.

¿Padece de alguna alergia?  Yes  No Si marcó 'Sí', por favor identifique la alergia específica a continuación.

Medicamentos                       Polen                                       Alimentos                                       Picaduras de insectos

*El padre/madre/tutor legal y el alumno(a) deben llenar completamente esta sección antes de participar en el programa deportivo interescolar. Explique las respuestas con "SI" a continuación. Marque con un círculo las preguntas que no sepa.*

PREGUNTAS GENERALES	Sí	No	PREGUNTAS MÉDICAS	Sí	No
1. ¿Alguna vez le ha negado un doctor la participación en los deportes por alguna razón?			26. ¿Tose, resolla o respira con dificultad durante o después de hacer ejercicio?		
2. ¿Padece de alguna afección médica constante? Si respondió 'Sí', por favor identifique la a continuación: <input type="checkbox"/> Asma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infecciones Otra: _____			27. ¿Ha usado alguna vez un inhalante o tomado medicina para el asma?		
3. ¿Alguna vez pasó la noche en el hospital?			28. ¿Alguien de su familia padece de asma?		
4. ¿Alguna vez tuvo alguna cirugía?			29. ¿Nació sin un riñón o le falta un riñón, un ojo, un testículo (hombres), el bazo o cualquier otro órgano?		
PREGUNTAS SOBRE SU SALUD CARDÍACA					
5. ¿Alguna vez se ha desmayado o ha estado a punto de hacerlo DURANTE o DESPUÉS de hacer ejercicio?			30. ¿Tiene dolor en la ingle o un bulto o hernia dolorosa en la ingle?		
6. ¿Ha sentido alguna vez incomodidad, dolor, tensión o presión en el pecho durante el ejercicio?			31. ¿Ha padecido de mononucleosis (mono) infecciosa en el último mes?		
7. ¿Su corazón a veces se acelera o late irregularmente durante el ejercicio?			32. ¿Tiene alguna erupción cutánea, llagas por presión u otro problema de la piel?		
8. ¿Alguna vez le ha dicho un doctor que padece de problemas cardiacos? Si respondió 'Sí', marque lo que corresponda: <input type="checkbox"/> Enfermedad de Kawasaki <input type="checkbox"/> Una infección cardíaca <input type="checkbox"/> Presión alta <input type="checkbox"/> Un soplo cardíaco <input type="checkbox"/> Colesterol alto                              Otro: _____			33. ¿Ha tenido una infección por herpes o de MRSA?		
9. ¿Alguna vez le ordenó el doctor una prueba del corazón (por ejemplo un electrocardiograma o ecocardiograma)?			34. ¿Ha tenido alguna lesión en la cabeza o conmoción cerebral?		
10. ¿Se marea o le falta el aire más de lo esperado durante el ejercicio?			35. ¿Ha tenido algún golpe o impacto a la cabeza que le causó confusión, dolor de cabeza prolongado o problemas de la memoria?		
11. ¿Ha tenido alguna vez algún ataque inexplicado?			36. ¿Tiene un historial de trastorno de ataques?		
12. ¿Se cansa o le falta el aire más rápidamente que a sus amigos durante el ejercicio?			37. ¿Le duele la cabeza cuando hace ejercicio?		
PREGUNTAS DE LA SALUD DE SU FAMILIA					
13. ¿Ha habido alguna muerte por problemas cardíacos o una muerte repentina e inesperada o inexplicable antes de los 50 años de algún miembro de su familia o pariente (incluyen ahogados, accidente automovilístico inexplicado, o síndrome de muerte infantil súbita)?			38. ¿Alguna vez ha sentido adormecimiento, hormigueo o debilidad en los brazos o piernas después de caerse o ser golpeado(a)?		
14. ¿Alguien de su familia padece de cardiomiopatía hipertrófica, síndrome de Marfan, cardiomiopatía arritmogénica del ventrículo derecho, síndrome de QT largo o corto, síndrome de Brugada o taquicardia catecolaminérgica polimórfica ventricular?			39. ¿Alguna vez no ha podido mover los brazos o las piernas luego de caerse o ser golpeado(a)?		
15. ¿Alguien de su familia padece de problemas cardíacos, tiene un marcapasos o desfibrilador implantado?			40. ¿Alguna vez le ha dado náuseas o vómito mientras hacía ejercicio en el calor?		
16. ¿Alguien de su familia se ha desmayado o ha tenido algún ataque inexplicable o ha estado a punto de ahogarse?			41. ¿Le dan calambres musculares frecuentes cuando hace ejercicio?		
PREGUNTAS SOBRE LOS HUESOS Y LAS ARTICULACIONES					
17. ¿Ha tenido alguna lesión, tal como una torcedura, desgarro muscular o de un ligamento o tendinitis, que le haya hecho faltar a la práctica o a algún juego?			42. ¿Usted o alguien de su familia tiene razgos de o padece de anemia drepanocítica?		
18. ¿Se ha roto o fracturado algún hueso o se ha dislocado alguna articulación?			43. ¿Ha tenido problemas de los ojos o la visión?		
19. ¿Ha tenido alguna lesión que ha requerido Rayos X, IRM, escaner, TAC, una terapia de inyecciones, un aparato ortopédico, yeso o muletas?			44. ¿Ha sufrido alguna lesión de los ojos?		
20. ¿Alguna vez ha tenido una fractura de fatiga?			45. ¿Usa anteojos o lentes de contacto?		
21. ¿Le han dicho alguna vez que se haga o se ha hecho una radiografía para la inestabilidad atlantoaxial o del cuello? (Síndrome de Down syndrome o enanismo)			46. ¿Usa lentes de protección, tales como gafas protectoras o protector facial?		
22. ¿Usa regularmente algún aparato ortopédico, ortótico o de asistencia?			47. ¿Le preocupa su peso?		
23. ¿Tiene alguna lesión del hueso, músculo o articulación que le moleste?			48. ¿Está tratando de bajar o subir de peso, o alguien se lo ha recomendado?		
24. ¿Alguna articulación le duele, se hincha, se siente tibia o se ve rojiza?			49. ¿Está en una dieta especial o evita ciertos tipos de comida?		
25. ¿Tiene un historial de artritis juvenil o enfermedad del tejido conectivo?			50. ¿Ha padecido alguna vez de un trastorno alimenticio?		
			51. ¿Tiene alguna inquietud que le gustaría tratar con un doctor?		
			<b>PARA MUJERES SOLAMENTE</b>		
			52. ¿Alguna vez ha tenido su periodo menstrual?		
			53. ¿A qué edad tuvo su primer periodo menstrual?		
			54. ¿Cuántos periodos ha tenido en los últimos 12 meses?		
			<b>Explique aquí las respuestas de "Si."</b>		

Por la presente indico que, a mi leal saber y entender, mis respuestas anteriores estan completas y correctas.

Firma del atleta \_\_\_\_\_ Firma del padre/madre/tutor legal \_\_\_\_\_ Fecha \_\_\_\_\_

# Physical Examination Form

The section below is to be completed by physician or staff after history and consent forms are completed.

ANEXO A-1

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ %BMI (optional): \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_, ( \_\_\_\_\_ / \_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_\_ )  
 Vision: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

## EMERGENCY INFORMATION

Allergies: \_\_\_\_\_  
 Other Information: \_\_\_\_\_

MEDICAL	Normal	Abnormal Findings
Appearance ● Marfan stigmata (kyphoscoliosis, high arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ Ears/ Nose/ Throat ● Pupils equal ● Hearing		
Lymph Nodes		
Heart <sup>1</sup> ● Murmurs (auscultation standing, supine, +/- Valsalva) ● Location of point of maximal impulse (PMI)		
Lungs		
Abdomen		
Genitourinary (males only) <sup>2</sup>		
Skin ● HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic <sup>3</sup>		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/ Arm		
Elbow/ Forearm		
Wrist/ Hand/ Fingers		
Hip/ Thigh		
Knee		
Leg/ Ankle		
Foot/ Toes		
Functional ● Duck walk, single leg hop		

<sup>1</sup> Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam

<sup>2</sup> Consider GU exam if in private setting. Having 3rd party present is recommended.

<sup>3</sup> Consider cognitive evaluation or baseline neuropsychiatric setting if a history of significant concussion.

## Clearance

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for: \_\_\_\_\_
- Not cleared
- Pending further evaluation  
For any sports
- For certain sports: \_\_\_\_\_

Reason/Recommendations: \_\_\_\_\_

I have evaluated the above-named student and completed the Pre-Participation Physical Evaluation. The athlete does not present apparent contraindications to practice, tryout and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parent. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of Physician/ Provider: (print/ type/ stamp) \_\_\_\_\_ (MD, DO, NP or PA) Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Physician/ Provider: \_\_\_\_\_

Modified from American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine, 2010.

## MEDICAL CONDITIONS AND SPORTS PARTICIPATION

Condition	May Participate
Atlantoaxial instability (instability of the joint between cervical vertebrae 1 and 2) Explanation: Athlete (particularly if he or she has Down syndrome or juvenile rheumatoid arthritis with cervical involvement) needs evaluation to assess the risk of spinal cord injury during sports participation, especially when using a trampoline. <sup>4-7</sup>	Qualified yes
Bleeding disorder Explanation: Athlete needs evaluation. <sup>8,9</sup>	Qualified yes
Cardiovascular disease	
Carditis (inflammation of the heart) Explanation: Carditis may result in sudden death with exertion.	No
Hypertension (high blood pressure) Explanation: Those with hypertension >5 mm Hg above the 99th percentile for age, gender, and height should avoid heavy weightlifting and power lifting, bodybuilding, and high-static component sports (Fig 1). Those with sustained hypertension (>95th percentile for age, gender, and height) need evaluation. <sup>10-12</sup> The National High Blood Pressure Education Program Working Group report defined prehypertension and stage 1 and stage 2 hypertension in children and adolescents younger than 18 years of age. <sup>10</sup>	Qualified yes
Congenital heart disease (structural heart defects present at birth) Explanation: Consultation with a cardiologist is recommended. Those who have mild forms may participate fully in most cases; those who have moderate or severe forms or who have undergone surgery need evaluation. The 36th Bethesda Conference <sup>12</sup> defined mild, moderate, and severe disease for common cardiac lesions.	Qualified yes
Dysrhythmia (irregular heart rhythm) Long-QT syndrome Malignant ventricular arrhythmias Symptomatic Wolff-Parkinson-White syndrome Advanced heart block Family history of sudden death or previous sudden cardiac event Implantation of a cardioverter-defibrillator Explanation: Consultation with a cardiologist is advised. Those with symptoms (chest pain, syncope, near-syncope, dizziness, shortness of breath, or other symptoms of possible dysrhythmia) or evidence of mitral regurgitation on physical examination need evaluation. All others may participate fully. <sup>13-15</sup>	Qualified yes
Heart murmur Explanation: If the murmur is innocent (does not indicate heart disease), full participation is permitted. Otherwise, athlete needs evaluation (see structural heart disease, especially hypertrophic cardiomyopathy and mitral valve prolapse).	Qualified yes
Structural/acquired heart disease	
Hypertrophic cardiomyopathy	Qualified no
Coronary artery anomalies	Qualified no
Arrhythmogenic right ventricular cardiomyopathy	Qualified no
Acute rheumatic fever with carditis	Qualified no
Ehlers-Danlos syndrome, vascular form	Qualified no
Marfan syndrome	Qualified yes
Mitral valve prolapse	Qualified yes
Anthracycline use Explanation: Consultation with a cardiologist is recommended. The 36th Bethesda Conference provided detailed recommendations. <sup>12,13,15-18</sup> Most of these conditions carry a significant risk of sudden cardiac death associated with intense physical exercise. Hypertrophic cardiomyopathy requires thorough and repeated evaluations, because disease may change manifestations during later adolescence. <sup>12,13,17</sup> Marfan syndrome with an aortic aneurysm also can cause sudden death during intense physical exercise. <sup>18</sup> Athlete who has ever received chemotherapy with anthracyclines may be at increased risk of cardiac problems because of the cardiotoxic effects of the medications, and resistance training in this population should be approached with caution; strength training that avoids isometric contractions may be permitted. <sup>19,20</sup> Athlete needs evaluation.	Qualified yes
Vasculitis/vascular disease	Qualified yes
Kawasaki disease (coronary artery vasculitis) Pulmonary hypertension Explanation: Consultation with a cardiologist is recommended. Athlete needs individual evaluation to assess risk on the basis of disease activity, pathologic changes, and medical regimen. <sup>21</sup>	
Cerebral palsy Explanation: Athlete needs evaluation to assess functional capacity to perform sports-specific activity.	Qualified yes
Diabetes mellitus Explanation: All sports can be played with proper attention and appropriate adjustments to diet (particularly carbohydrate intake), blood glucose concentrations, hydration, and insulin therapy. Blood glucose concentrations should be monitored before exercise, every 30 min during continuous exercise, 15 min after completion of exercise, and at bedtime.	Yes
Diarrhea, infectious Explanation: Unless symptoms are mild and athlete is fully hydrated, no participation is permitted, because diarrhea may increase risk of dehydration and heat illness (see fever).	Qualified no
Eating disorders Explanation: Athlete with an eating disorder needs medical and psychiatric assessment before participation.	Qualified yes
Eyes	Qualified yes
Functionally 1-eyed athlete Loss of an eye Detached retina or family history of retinal detachment at young age High myopia Connective tissue disorder, such as Marfan or Stickler syndrome Previous intraocular eye surgery or serious eye injury	

## MEDICAL CONDITIONS AND SPORTS PARTICIPATION

Condition	May Participate
Explanation: A functionally 1-eyed athlete is defined as having best-corrected visual acuity worse than 20/40 in the poorer-seeing eye. Such an athlete would suffer significant disability if the better eye were seriously injured, as would an athlete with loss of an eye. Specifically, boxing and full-contact martial arts are not recommended for functionally 1-eyed athletes, because eye protection is impractical and/or not permitted. Some athletes who previously underwent intraocular eye surgery or had a serious eye injury may have increased risk of injury because of weakened eye tissue. Availability of eye guards approved by the American Society for Testing and Materials and other protective equipment may allow participation in most sports, but this must be judged on an individual basis. <sup>22,23</sup>	
Conjunctivitis, infectious Explanation: Athlete with active infectious conjunctivitis should be excluded from swimming.	Qualified no
Fever Explanation: Elevated core temperature may be indicative of a pathologic medical condition (infection or disease) that is often manifest by increased resting metabolism and heart rate. Accordingly, during athlete's usual exercise regimen, the presence of fever can result in greater heat storage, decreased heat tolerance, increased risk of heat illness, increased cardiopulmonary effort, reduced maximal exercise capacity, and increased risk of hypotension because of altered vascular tone and dehydration. On rare occasions, fever may accompany myocarditis or other conditions that may make usual exercise dangerous.	No
Gastrointestinal Malabsorption syndromes (celiac disease or cystic fibrosis) Explanation: Athlete needs individual assessment for general malnutrition or specific deficits resulting in coagulation or other defects; with appropriate treatment, these deficits can be treated adequately to permit normal activities. Short-bowel syndrome or other disorders requiring specialized nutritional support, including parenteral or enteral nutrition Explanation: Athlete needs individual assessment for collision, contact, or limited-contact sports. Presence of central or peripheral, indwelling, venous catheter may require special considerations for activities and emergency preparedness for unexpected trauma to the device(s).	Qualified yes
Heat illness, history of Explanation: Because of the likelihood of recurrence, athlete needs individual assessment to determine the presence of predisposing conditions and behaviors and to develop a prevention strategy that includes sufficient acclimatization (to the environment and to exercise intensity and duration), conditioning, hydration, and salt intake, as well as other effective measures to improve heat tolerance and to reduce heat injury risk (such as protective equipment and uniform configurations). <sup>24,25</sup>	Qualified yes
Hepatitis, infectious (primarily hepatitis C) Explanation: All athletes should receive hepatitis B vaccination before participation. Because of the apparent minimal risk to others, all sports may be played as athlete's state of health allows. For all athletes, skin lesions should be covered properly, and athletic personnel should use universal precautions when handling blood or body fluids with visible blood. <sup>26</sup>	Yes
HIV infection Explanation: Because of the apparent minimal risk to others, all sports may be played as athlete's state of health allows (especially if viral load is undetectable or very low). For all athletes, skin lesions should be covered properly, and athletic personnel should use universal precautions when handling blood or body fluids with visible blood. <sup>26</sup> However, certain sports (such as wrestling and boxing) may create a situation that favors viral transmission (likely bleeding plus skin breaks). If viral load is detectable, then athletes should be advised to avoid such high-contact sports.	Yes
Kidney, absence of one Explanation: Athlete needs individual assessment for contact, collision, and limited-contact sports. Protective equipment may reduce risk of injury to the remaining kidney sufficiently to allow participation in most sports, providing such equipment remains in place during activity. <sup>22</sup>	Qualified yes
Liver, enlarged Explanation: If the liver is acutely enlarged, then participation should be avoided because of risk of rupture. If the liver is chronically enlarged, then individual assessment is needed before collision, contact, or limited-contact sports are played. Patients with chronic liver disease may have changes in liver function that affect stamina, mental status, coagulation, or nutritional status.	Qualified yes
Malignant neoplasm Explanation: Athlete needs individual assessment. <sup>27</sup>	Qualified yes
Musculoskeletal disorders Explanation: Athlete needs individual assessment.	Qualified yes
Neurologic disorders History of serious head or spine trauma or abnormality, including craniotomy, epidural bleeding, subdural hematoma, intracerebral hemorrhage, second-impact syndrome, vascular malformation, and neck fracture. <sup>4,5,28-30</sup> Explanation: Athlete needs individual assessment for collision, contact, or limited-contact sports.	Qualified yes
History of simple concussion (mild traumatic brain injury), multiple simple concussions, and/or complex concussion Explanation: Athlete needs individual assessment. Research supports a conservative approach to concussion management, including no athletic participation while symptomatic or when deficits in judgment or cognition are detected, followed by graduated return to full activity. <sup>28-32</sup>	Qualified yes
Myopathies Explanation: Athlete needs individual assessment.	Qualified yes
Recurrent headaches Explanation: Athlete needs individual assessment. <sup>33</sup>	Yes
Recurrent plexopathy (burner or stinger) and cervical cord neuropraxia with persistent defects Explanation: Athlete needs individual assessment for collision, contact, or limited-contact sports; regaining normal strength is important benchmark for return to play. <sup>34,35</sup>	Qualified yes
Seizure disorder, well controlled Explanation: Risk of seizure during participation is minimal. <sup>36</sup>	Yes
Seizure disorder, poorly controlled Explanation: Athlete needs individual assessment for collision, contact, or limited-contact sports. The following noncontact sports should be avoided: archery, riflery, swimming, weightlifting, power lifting, strength training, and sports involving heights. In these sports, occurrence of a seizure during activity may pose a risk to self or others. <sup>36</sup>	Qualified yes

## MEDICAL CONDITIONS AND SPORTS PARTICIPATION

Condition	May Participate
Obesity Explanation: Because of the increased risk of heat illness and cardiovascular strain, obese athlete particularly needs careful acclimatization (to the environment and to exercise intensity and duration), sufficient hydration, and potential activity and recovery modifications during competition and training. <sup>37</sup>	Yes
Organ transplant recipient (and those taking immunosuppressive medications) Explanation: Athlete needs individual assessment for contact, collision, and limited-contact sports. In addition to potential risk of infections, some medications (eg, prednisone) may increase tendency for bruising.	Qualified yes
Ovary, absence of one Explanation: Risk of severe injury to remaining ovary is minimal.	Yes
Pregnancy/postpartum Explanation: Athlete needs individual assessment. As pregnancy progresses, modifications to usual exercise routines will become necessary. Activities with high risk of falling or abdominal trauma should be avoided. Scuba diving and activities posing risk of altitude sickness should also be avoided during pregnancy. After the birth, physiological and morphologic changes of pregnancy take 4 to 6 weeks to return to baseline. <sup>38,39</sup>	Qualified yes
Respiratory conditions	
Pulmonary compromise, including cystic fibrosis Explanation: Athlete needs individual assessment but, generally, all sports may be played if oxygenation remains satisfactory during graded exercise test. Athletes with cystic fibrosis need acclimatization and good hydration to reduce risk of heat illness.	Qualified yes
Asthma Explanation: With proper medication and education, only athletes with severe asthma need to modify their participation. For those using inhalers, recommend having a written action plan and using a peak flowmeter daily. <sup>40-43</sup> Athletes with asthma may encounter risks when scuba diving.	Yes
Acute upper respiratory infection Explanation: Upper respiratory obstruction may affect pulmonary function. Athlete needs individual assessment for all except mild disease (see fever).	Qualified yes
Rheumatologic diseases	Qualified yes
Juvenile rheumatoid arthritis Explanation: Athletes with systemic or polyarticular juvenile rheumatoid arthritis and history of cervical spine involvement need radiographs of vertebrae C1 and C2 to assess risk of spinal cord injury. Athletes with systemic or HLA-B27-associated arthritis require cardiovascular assessment for possible cardiac complications during exercise. For those with micrognathia (open bite and exposed teeth), mouth guards are helpful. If uveitis is present, risk of eye damage from trauma is increased; ophthalmologic assessment is recommended. If visually impaired, guidelines for functionally 1-eyed athletes should be followed. <sup>44</sup>	
Juvenile dermatomyositis, idiopathic myositis Systemic lupus erythematosus Raynaud phenomenon Explanation: Athlete with juvenile dermatomyositis or systemic lupus erythematosus with cardiac involvement requires cardiology assessment before participation. Athletes receiving systemic corticosteroid therapy are at higher risk of osteoporotic fractures and avascular necrosis, which should be assessed before clearance; those receiving immunosuppressive medications are at higher risk of serious infection. Sports activities should be avoided when myositis is active. Rhabdomyolysis during intensive exercise may cause renal injury in athletes with idiopathic myositis and other myopathies. Because of photosensitivity with juvenile dermatomyositis and systemic lupus erythematosus, sun protection is necessary during outdoor activities. With Raynaud phenomenon, exposure to the cold presents risk to hands and feet. <sup>45-48</sup>	
Sickle cell disease Explanation: Athlete needs individual assessment. In general, if illness status permits, all sports may be played; however, any sport or activity that entails overexertion, overheating, dehydration, or chilling should be avoided. Participation at high altitude, especially when not acclimatized, also poses risk of sickle cell crisis.	Qualified yes
Sickle cell trait Explanation: Athletes with sickle cell trait generally do not have increased risk of sudden death or other medical problems during athletic participation under normal environmental conditions. However, when high exertional activity is performed under extreme conditions of heat and humidity or increased altitude, such catastrophic complications have occurred rarely. <sup>8,49-52</sup> Athletes with sickle cell trait, like all athletes, should be progressively acclimatized to the environment and to the intensity and duration of activities and should be sufficiently hydrated to reduce the risk of exertional heat illness and/or rhabdomyolysis. <sup>25</sup> According to National Institutes of Health management guidelines, sickle cell trait is not a contraindication to participation in competitive athletics, and there is no requirement for screening before participation. <sup>53</sup> More research is needed to assess fully potential risks and benefits of screening athletes for sickle cell trait.	Yes
Skin infections, including herpes simplex, molluscum contagiosum, verrucae (warts), staphylococcal and streptococcal infections (furuncles [boils], carbuncles, impetigo, methicillin-resistant <i>Staphylococcus aureus</i> [cellulitis and/or abscesses]), scabies, and tinea Explanation: During contagious periods, participation in gymnastics or cheerleading with mats, martial arts, wrestling, or other collision, contact, or limited-contact sports is not allowed. <sup>54-57</sup>	Qualified yes
Spleen, enlarged Explanation: If the spleen is acutely enlarged, then participation should be avoided because of risk of rupture. If the spleen is chronically enlarged, then individual assessment is needed before collision, contact, or limited-contact sports are played.	Qualified yes
Testicle, undescended or absence of one Explanation: Certain sports may require a protective cup. <sup>22</sup>	Yes

This table is designed for use by medical and nonmedical personnel. "Needs evaluation" means that a physician with appropriate knowledge and experience should assess the safety of a given sport for an athlete with the listed medical condition. Unless otherwise noted, this need for special consideration is because of variability in the severity of the disease, the risk of injury for the specific sports listed in Table 1, or both.

Interscholastic Athletics Department  
**CONCUSSION INJURY REPORT / REPORTE DE LESIÓN CONTUSIVA**  
 (Required for LAUSD Athletes Only)

ATTACHMENT C



SCHOOL FIRST RESPONDER AT TIME OF INJURY			
Name:		Date:	
Signature:		Title:	
Tools: SAC: <input type="checkbox"/> ____/30	LOSS OF CONCIOSNESS (LOC): <input type="checkbox"/> NO <input type="checkbox"/> YES DURATION _____		
BESS: <input type="checkbox"/> ____/30	DISPOSITION FROM LOCATION: EMS <input type="checkbox"/> PRIVATE VEHICLE <input type="checkbox"/>		
APP: <input type="checkbox"/> _____	RELEASED TO PARENT/GUARDIAN. Time: _____		
Name of Athlete / Nombre del deportista:		DOB / Fecha de Nacimiento:	Gender / Género <input type="checkbox"/> F <input type="checkbox"/> M
School / Escuela:		Home Phone / No. de teléfono:	Sport / Deporte:
Date of Injury / Fecha en que ocurrió la lesión:	Time of Injury / Hora en que se lesionó:	Location Injury Occurred / Lugar donde ocurrió la lesión:	

**PARENT/GUARDIAN:**

Your child is suspected of sustaining a concussion or head injury. Quite often, signs and symptoms of a head injury do not appear immediately, but can appear hours later. The purpose of this report is to alert you to the signs and symptoms of a worsening concussion or head injury. \*According to state law, students who are suspected of having a concussion must have a graduated "Return to Play" (RTP) protocol of no less than seven days duration under the supervision of a licensed health care provider (MD/DO). Please have your physician complete the bottom of this form and approve the "Return to Play" (RTP) protocol on back of this page.

**PADRE/MADRE/TUTOR LEGAL:**

Se sospecha que su hijo/a ha sufrido una contusión o lesión en la cabeza. Muy a menudo los signos y síntomas de una lesión en la cabeza no se manifiestan inmediatamente, pero pueden presentarse horas después. El propósito de este reporte es alertarle sobre las signos y síntomas de una contusión o lesión en la cabeza que esté empeorando. \*De acuerdo con ley estatal, si se sospecha que un estudiante ha sufrido una contusión, el estudiante debe seguir el protocolo gradual de observación para "Regresar al Juego" ("Return to Play", por sus siglas en inglés) por una duración de no menos de siete días, bajo la supervisión de un proveedor médico autorizado (Doctor en Medicina/Doctor en Medicina Osteopatía). Por favor pida a su doctor que llene la parte al pie de la página y además que apruebe el protocolo para "Regresar al Juego" que se encuentra al reverso de esta hoja.

Today, the following symptoms were present (check ✓) / El día de hoy se presentan los siguientes síntomas (marque con una ✓):

PHYSICAL / FISICO	PHYSICAL / FISICO	THINKING / RAZONAMIENTO	EMOTIONAL / EMOCIONAL
<input type="checkbox"/> Loss of consciousness <i>Perdida del conocimiento</i>	<input type="checkbox"/> Visual problems or Sensitivity to light <i>Problemas visuales o Sensibilidad a la luz</i>	<input type="checkbox"/> Problems remembering <i>Problemas recordando</i>	<input type="checkbox"/> Irritable / Irritabilidad
<input type="checkbox"/> Headaches <i>Dolores de cabeza</i>	<input type="checkbox"/> Sensitivity to noise <i>Sensibilidad al ruido</i>	<input type="checkbox"/> Problems concentrating <i>Problemas de concentración</i>	<input type="checkbox"/> Sadness / Tristeza
<input type="checkbox"/> Nausea / Vomiting <i>Nausea / Vómito</i>	<input type="checkbox"/> Numbness / Tingling <i>Adormecimiento / Hormigeo</i>	<input type="checkbox"/> Mentally foggy / Drowsiness <i>Mentalmente confuso / Somnolencia</i>	<input type="checkbox"/> Feeling more emotional <i>Sintiendose mas sensible</i>
<input type="checkbox"/> Fatigue / Fatiga	<input type="checkbox"/> Dizziness / Mareos <input type="checkbox"/> Balance Problems / Problemas de equilibrio	<input type="checkbox"/> Feeling more slowed down <i>Sintiendose mas lento</i>	<input type="checkbox"/> Nervousness / Nerviosismo

**RED FLAGS: CALL 911, YOUR DOCTOR OR GO TO THE NEAREST EMERGENCY ROOM IF YOUR CHILD SUDDENLY EXPERIENCES ANY OF THE FOLLOWING:**  
**ALERTA ROJA: LLAME AL 911, A SU MÉDICO O DIRÍJASE A LA SALA DE URGENCIAS MÁS CERCANA SI SU HIJO REPENTINAMENTE MANIFIESTA LOS SIGUIENTES SINTOMAS:**

Headaches that WORSEN <i>Dolores de cabeza que empeoran</i>	Very drowsy or cannot be awakened <i>Muy somnoliento o dificultad despertando</i>	Does not recognize people or places <i>No reconoce a gente o lugares</i>	Unusual behavior change <i>Cambio inusual de comportamiento</i>
Seizures / Convulsiones	Repeated vomiting / Vómito repetitivo	Increasing confusion / Intensa confusion	Increasing irritability / Intensa irritabilidad
Neck pain / Dolor en el cuello	Slurred speech / Balbuceo	Weakness or numbness in arms or legs <i>Debilidad o adormecimiento en los brazos y piernas</i>	Loss of consciousness <i>Perdida del conocimiento</i>

**CONSENT: I, the Parent/Guardian, authorize release of information about concussion and management between LAUSD and my child's health care provider.**  
**CONSENTIMIENTO: Yo, padre/madre/tutor legal, autorizo a que la información sobre la contusión y su tratamiento sea compartida entre el proveedor médico autorizado de mi hijo/a y el Distrito Escolar Unificado de Los Angeles.**

Print Name / Escriba el nombre en letra de molde:	Parent Signature / Firma del padre/madre/tutor legal:	Date:
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**TO BE COMPLETED BY EXAMINING PHYSICIAN**

Was imaging done? None <input type="checkbox"/> CT Scan <input type="checkbox"/> MRI <input type="checkbox"/> X-Ray <input type="checkbox"/>	Date seen:
DIAGNOSIS:	

I have reviewed the above history of concussion symptoms and concur that a concussion occurred or is likely to have occurred.  
 I have reviewed and agree with the Return to Play Protocol attached to this form.  
 I have attached my own signed Return to Play protocol.

Licensed Health Care Provider/Hospital/Urgent Care (print or stamp) Name: Address: Telephone No.:	Signature of Health Care Provider (MD/DO):
--	--

\*CIF State Bylaw 313 states: A student athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time for the remainder of the day. A student-athlete who has been removed from play may not return to play until the athlete is evaluated by a licensed health care provider trained in the evaluation and management of concussion and receives written clearance to return to play from that health care provider. In addition, CA State Law AB2127 states that return to play cannot be sooner than 7 days after evaluation by a licensed health care provider who has made the diagnosis of concussion.

\*El estatuto 313 de la CIF estatal indica que: Un alumno deportista en quien se sospeche haber sufrido una contusión o lesión en la cabeza, durante entrenamiento o juego, deberá ser removido de la competencia durante el resto del día. También, el alumno quien ha sido removido del juego no puede volver a jugar hasta que éste mismo haya sido evaluado por un proveedor médico autorizado para evaluar y tratar contusiones y recibir, de parte del proveedor médico autorizado, una autorización por escrito para retornar al juego. Además, la Ley AB2127 del Estado de California indica que no se puede retornar a jugar antes de 7 días después de la evaluación realizada por un proveedor médico autorizado, quien realizó el diagnóstico de la contusión.



# Los Angeles Unified School District Concussion Return to Play (RTP) Protocol

CA STATE LAW AB 2127 (Effective 1/1/15) STATES THAT RETURN TO PLAY (I.E., COMPETITION) CANNOT BE SOONER THAN 7 DAYS AFTER EVALUATION BY A PHYSICIAN (MD/DO) WHO HAS MADE THE DIAGNOSIS OF CONCUSSION.

**Instructions:**

- This graduated return to play protocol **MUST** be completed before you can return to FULL COMPETITION.
  - A certified athletic trainer (AT), physician, or identified concussion monitor (e.g., coach, athletic director), must initial each stage after you successfully pass it.
  - Stages I to II-D take a *minimum* of 6 days to complete.
  - You must be back to normal academic activities before beginning Stage II.
  - You must complete one full practice *without restrictions* (Stage III) before competing in first game.
- After Stage I, you cannot progress more than one stage per day (or longer if instructed by your physician).
- If symptoms return at any stage in the progression, IMMEDIATELY STOP any physical activity and follow up with your school's AT, other identified concussion monitor, or your physician. In general, if you are symptom-free the next day, return to the previous stage where symptoms had not occurred.
- Seek further medical attention if you cannot pass a stage after 3 attempts due to concussion symptoms, or if you feel uncomfortable at any time during the progression.

Concussion Monitor: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
NAME (please print) POSITION SIGNATURE

Athlete: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Concussion Diagnosis Date: \_\_\_\_\_  
NAME (please print) SPORT SCHOOL

You must have written physician (MD/DO) clearance to begin and progress through the following Stages as outlined below (or as otherwise directed by physician)

Nurse Verification of Physician Clearance: \_\_\_\_\_  
NAME (please print) SIGNATURE DATE

Date & Initials	Stage	Activity	Exercise Example	Objective of the Stage
	I	No physical activity for at least 2 full symptom-free days <u>AFTER</u> you have seen a physician	No activities requiring exertion (weight lifting, jogging, P.E. classes)	Recovery and elimination of symptoms
	II-A	Light aerobic activity	<ul style="list-style-type: none"> <li>10-15 minutes of walking or stationary biking</li> <li><b>Must be performed under direct supervision by designated individual</b></li> </ul>	<ul style="list-style-type: none"> <li>Increase heart rate to no more than 50% of perceived max. exertion (e.g., &lt;100 beats per minute)</li> <li>Monitor for symptom return</li> </ul>
	II-B	Moderate aerobic activity Light resistance training	<ul style="list-style-type: none"> <li>20-30 minutes jogging or stationary biking</li> <li>Body weight exercises (squats, planks, push-ups), max 1 set of 10, no more than 10 min total</li> </ul>	<ul style="list-style-type: none"> <li>Increase heart rate to 50-75% max. exertion (e.g., 100-150 bpm)</li> <li>Monitor for symptom return</li> </ul>
	II-C	Strenuous aerobic activity Moderate resistance training	<ul style="list-style-type: none"> <li>30-40 minutes running or stationary biking</li> <li>Weight lifting ≤ 50% of max weight</li> </ul>	<ul style="list-style-type: none"> <li>Increase heart rate to &gt; 75% max. exertion</li> <li>Monitor for symptom return</li> </ul>
	II-D	Non-contact training with sport-specific drills No restriction for weightlifting	<ul style="list-style-type: none"> <li>Non-contact drills, sport-specific activities (cutting, jumping, sprinting)</li> <li>No contact with people, padding or the floor/mat</li> </ul>	<ul style="list-style-type: none"> <li>Add total body movement</li> <li>Monitor for symptom return</li> </ul>

Minimum of 6 days to pass Stage I and II. Prior to beginning Stage III, please make sure that written physician (MD/DO) clearance for return to play, after successful completion of Stages I and II has been given to your school's concussion monitor

Nurse Verification of Clearance for Return to Play Stage III: \_\_\_\_\_  
NAME (please print) SIGNATURE DATE

	III	Limited contact practice Full contact practice	<ul style="list-style-type: none"> <li>Controlled contact drills allowed (no scrimmaging)</li> <li>Return to normal training (with contact)</li> </ul>	<ul style="list-style-type: none"> <li>Increase acceleration, deceleration and rotational forces</li> <li>Restore confidence, assess readiness for return to play</li> <li>Monitor for symptom return</li> </ul>
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**MANDATORY:** You must complete at least ONE contact practice before return to competition (Highly recommend that Stage III be divided into 2 contact practice days as outlined above.)

	IV	Return to play (competition)	Normal game play	Return to full sports activity without restrictions
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Interscholastic Athletics Department  
**CONFIDENTIAL ATHLETIC INJURY TRACKING FORM**  
 (Required for LAUSD Athletes Only)

ATTACHMENT E

**It is the responsibility of the Coach to complete this form. Use a separate form for each incident or student. Copies of this form must be given to the School Nurse and Assistant Principal/Athletics NO LATER than 24 hours following the injury or incident. A copy must also be forwarded to the LAUSD Athletics office.**

<b>School of Incident:</b>			<b>ISTAR #</b>		
<b>Head Coach:</b>		<b>Supervising Adult:</b>		<b>Sport:</b>	
<b>Date of Incident:</b>		<b>Time of Incident:</b>		<b>Level (JV, Var, etc.):</b>	
<b>Name of Student:</b>				<b>DOB:</b>	<b>Age:</b>
<b>Gender:</b> <input type="checkbox"/> F <input type="checkbox"/> M	<b>Grade:</b>	<b>School of Attendance:</b>			
<b>Student Address:</b>					
<b>Student Home Phone:</b>				<b>Cell:</b>	
<b>Parent/Guardian Name:</b>					

<b>Nature/Injury/Body Part affected:</b>	
<b>Suspected Concussion*?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

*\*If a Concussion is suspected/diagnosed, a "Concussion Injury Report" must be completed. Also, CIF State Bylaw 313 states: A student athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time for the remainder of the day. A student-athlete who has been removed from play may not return to play until the athlete is evaluated by a licensed health care provider trained in the evaluation and management of concussion and receives written clearance to return to play from that health care provider.*

<b>ACTIONS TAKEN (Indicate N/A if not applicable)</b>	<b>DATE</b>	<b>TIME</b>	<b>COMMENTS</b>
Parent/Guardian Notified (and by whom)			
School Nurse Notified			
911 called/Taken to Emergency Room by Paramedics			
Taken to Emergency Room by Parents			
Referred to Licensed Health Care Provider			
Athletic Director Notified			
Assistant Principal/Athletics Notified			
Principal Notified			
Follow up with parent conducted (and by whom)			
Cleared without restriction by Health Care Provider			
Copy of this form to School Nurse			
Copy of this form to Asst. Principal/Athletics			
Copy of this form to Principal			
Copy of this form to LAUSD Athletics office			
School obtained witness statements			

A student absent from athletic practice or competition for *five or more consecutive days due to illness or injury* must present a written statement from the licensed health care provider indicating the diagnosis and a recommendation for return to athletic participation. The **school nurse** will determine eligibility and notify the coach. Any student returning from a serious injury with written approval from the licensed health care provider **must be referred to the school nurse for evaluation prior to resuming competitive athletics** (BUL-4948.2).

<b>Coach's Signature:</b>		<b>Date:</b>	
<b>Name of Coach (please print):</b>			