



## Concussion Information Sheet

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

### Symptoms may include one or more of the following:

- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>• Headaches</li><li>• “Pressure in head”</li><li>• Nausea or vomiting</li><li>• Neck pain</li><li>• Balance problems or dizziness</li><li>• Blurred, double, or fuzzy vision</li><li>• Sensitivity to light or noise</li><li>• Feeling sluggish or slowed down</li><li>• Feeling foggy or groggy</li><li>• Drowsiness</li><li>• Change in sleep patterns</li></ul> | <ul style="list-style-type: none"><li>• Amnesia</li><li>• “Don’t feel right”</li><li>• Fatigue or low energy</li><li>• Sadness</li><li>• Nervousness or anxiety</li><li>• Irritability</li><li>• More emotional</li><li>• Confusion</li><li>• Concentration or memory problems (forgetting game plays)</li><li>• Repeating the same question/comment</li></ul> |
|--|--|

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

- |   |
|---|
| <ul style="list-style-type: none"><li>• Appears dazed</li><li>• Vacant facial expression</li><li>• Confused about assignment</li><li>• Forgets plays</li><li>• Is unsure of game, score, or opponent</li><li>• Moves clumsily or displays incoordination</li><li>• Answers questions slowly</li><li>• Slurred speech</li><li>• Shows behavior or personality changes</li><li>• Can’t recall events prior to hit</li><li>• Can’t recall events after hit</li><li>• Seizures or convulsions</li><li>• Any change in typical behavior or personality</li><li>• Loses consciousness</li></ul> |
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## **Concussion Information Sheet (Cont.)**

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

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

### **If you think your child has suffered a concussion**

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. IHSA Policy requires athletes to provide their school with written clearance from either a physician licensed to practice medicine in all its branches or a certified athletic trainer working in conjunction with a physician licensed to practice medicine in all its branches prior to returning to play or practice following a concussion or after being removed from an interscholastic contest due to a possible head injury or concussion and not cleared to return to that same contest. In accordance with state law, all IHSA member schools are required to follow this policy.

You should also inform your child's coach if you think that your child may have a concussion. Remember it's better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

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



### **IHSA Performance-Enhancing Substance Testing Policy**

In 2008, the IHSA Board of Directors established the association's Performance-Enhancing Substance (PES) Testing Program. Any student who participates in an IHSA-approved or sanctioned athletic event is subject to PES testing. A full copy of the testing program and other related resources can be accessed on the IHSA Sports Medicine website. Additionally, links to the PES Policy and the association's Banned Drug classes are listed below. School administrators are able to access the necessary resources used for program implementation in the IHSA Schools Center.

#### **IHSA PES Testing Program**

<http://www.ihsa.org/documents/sportsMedicine/2013-14/2013-14%20PES%20policy%20final.pdf>

#### **IHSA Banned Drug Classes**

<http://www.ihsa.org/documents/sportsMedicine/2013-14/2013-14%20IHSA%20Banned%20Drugs.pdf>

*insert Consent Language here (w/o signature lines)*

### **IHSA Steroid Testing Policy Consent to Random Testing**

As a prerequisite to participation in IHSA athletic activities, we agree that I/our student will not use performance-enhancing substances as defined in the IHSA Performance-Enhancing Substance Testing Program Protocol. We have reviewed the policy and understand that I/our student may be asked to submit to testing for the presence of performance-enhancing substances in my/our student's body either during IHSA state series events or during the school day, and I/our student do/does hereby agree to submit to such testing and analysis by a certified laboratory. We further understand and agree that the results of the performance-enhancing substance testing may be provided to certain individuals in my/our student's high school as specified in the IHSA Performance-Enhancing Substance Testing Program Protocol which is available on the IHSA website at [www.IHSA.org](http://www.IHSA.org). We understand and agree that the results of the performance-enhancing substance testing will be held confidential to the extent required by law. We understand that failure to provide accurate and truthful information could subject me/our student to penalties as determined by IHSA.

A complete list of the current IHSA Banned Substance Classes can be accessed at [http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA\\_banned\\_substance\\_classes.pdf](http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA_banned_substance_classes.pdf)



## **IHSA Sports Medicine Acknowledgement & Consent Form**

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## IHSA Sports Medicine Acknowledgement & Consent Form

### Acknowledgement and Consent

#### Student/Parent Consent and Acknowledgements

By signing this form, we acknowledge we have been provided information regarding concussions and the IHSA Performance-Enhancing Testing Policy. We also acknowledge that we are providing consent to be tested in accordance with the procedures outlined in the IHSA Performance-Enhancing Testing Policy.

#### STUDENT

Student Name (Print): \_\_\_\_\_ Grade (9-12) \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### PARENT or LEGAL GUARDIAN

Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

#### Consent to Self Administer Asthma Medication

As a patient under my care, \_\_\_\_\_, is prescribed to self-administer the following asthma medication.

Medication \_\_\_\_\_

Purpose \_\_\_\_\_

Dosage \_\_\_\_\_

Time/Special Circumstances \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Printed Name of Physician

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

I, \_\_\_\_\_, do hereby give my son/daughter, \_\_\_\_\_,  
Permission to self-administer his/her asthma medication as prescribed by his/her physician during athletic competition.

\_\_\_\_\_  
Printed Name of Parent/Guardian

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date



## **IHSA Sports Medicine Acknowledgement & Consent Form**

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## HONONEGAH HIGH SCHOOL ATHLETICS



### EMERGENCY INFORMATION FORM

Forms must be completed thoroughly then returned to Athletic Director **Prior to participation**

SPORT(S) I PLAN TO PARTICIPATE IN: 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Year in school: (circle one) Freshman Sophomore Junior Senior

#### PERMISSION FOR TREATMENT

Permission is hereby granted to attending medical personnel to provide needed medical or surgical treatment, dispense medication, and conduct diagnostics for:

STUDENT-ATHLETE NAME \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

##### PLEASE PRINT NAME

In the event of serious illness or injury, or the need for major surgery, I understand that an attempt will be made by a physician, coach or other representative of Hononegah High School to contact my parent, guardian or other designated contact. If said physician or representative is unable to communicate with a parent/guardian, permission is granted for the necessary treatment to be given for the above named student – athlete. This shall be valid as long as I participate in Hononegah High School athletics until graduation, transfer or revoked in writing by me.

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

#### PERMISSION FOR RELEASE OF INFORMATION

I, \_\_\_\_\_ understand that it is sometimes necessary to discuss and/or forward my medical information both past and present with other authorized medical staff in the best interest of my continued healthcare. Authorized medical staff would include Certified Athletic Trainers, student athletic training assistants, school nurse, Team physicians, and their staff, and my personal physician as designated by me. Further, as an athlete I understand that my injury/health status as it pertains to my sport needs to be reported to my coach and/or athletic director.

Therefore, I give my permission to release medical information under these circumstances. This shall be valid as long as I participate in Hononegah High School athletics until graduation, transfer or revoked in writing by me.

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

#### EMERGENCY INFORMATION AND CONTACTS

**ALLERGIES** \_\_\_\_\_ **Current Medications** \_\_\_\_\_

Contact lenses	Y	N	Hard or Soft	_____	Epilepsy	Y	N	Asthma	Y	N
Glasses	Y	N			Diabetes	Y	N	Hearing Problem	Y	N
Kidney condition/injury	Y	N			Dental Appliances	Y	N	Where?	_____	
Heart condition/disease	Y	N			Screws/Plates	Y	N	Where?	_____	
Last tetanus shot:	____/____/____				Other	_____				

Other Current Medical Conditions \_\_\_\_\_

Parent/Guardian full name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

**Work Phone:** Mother (\_\_\_\_) \_\_\_\_\_ Father (\_\_\_\_) \_\_\_\_\_ **Cell Phone:** Mother (\_\_\_\_) \_\_\_\_\_ Father (\_\_\_\_) \_\_\_\_\_

If unable to reach parent(s) call: Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Hospital Preference \_\_\_\_\_ Primary Care Physician (PCP) \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

**The information supplied is true to the best of my knowledge and belief.**

**Parent/Guardian Signature:** \_\_\_\_\_

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Post-concussion Consent Form  
(RTP/RTL)



Date \_\_\_\_\_

Student's Name \_\_\_\_\_ Year in School 9 10 11 12

By signing below, I acknowledge the following:

1. I have been informed concerning and consent to my student's participating in returning to play in accordance with the return-to-play and return-to-learn protocols established by Illinois State law;
2. I understand the risks associated with my student returning to play and returning to learn and will comply with any ongoing requirements in the return-to-play and return-to-learn protocols established by Illinois State law;
3. And I consent to the disclosure to appropriate persons, consistent with the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), of the treating physician's or athletic trainer's written statement, and, if any, the return-to-play and return-to-learn recommendations of the treating physician or the athletic trainer, as the case may be.

Student's Signature \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_

Parent/Guardian/s Signature \_\_\_\_\_

**For School Use only**

☐

Written statement is included with this consent from treating physician or athletic trainer working under the supervision of a physician that indicates, in the individual's professional judgement, it is safe for the student to return-to-play and return-to-learn.

**Cleared for RTL**

Date \_\_\_\_\_

**Cleared for RTP**

Date \_\_\_\_\_

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## HONONEGAH ATHLETIC/ACTIVITY PLEDGE SHEET

**Student Athlete (print):**

**Sport:**

**Student:**

I agree to accept any role given to me by the coaching staff or activity advisor and will give 100% effort while maintaining a positive attitude and promoting good sportsmanship.

As an athlete, I pledge to be drug/alcohol/tobacco free at all times. I understand that my performance as a participant and the reputation of my school are dependent, in part, on my conduct as an individual. I hereby agree to accept and abide by the policies, standards, rules and regulations set forth by the Hononegah Community High School Board of Education and the sponsors for the activity in which I participate.

I authorize Hononegah Community High School to conduct random tests for one calendar year and the release of information concerning the results of such a test to the District and parents or guardians of the student.

By signing below, I consent to random testing in accordance with the IHSA's steroid testing policy.

**Parent/Guardians:**

We as parents will support the sportsmanship policy of Hononegah Community High School and the "Sport a Winning Attitude" program from the Illinois High School Association (IHSA).

We understand and take responsibility for understanding the risk involved in playing interscholastic athletics and that there is a possibility of injury and the potential of death. Hononegah Community High School does not provide medical insurance coverage for students involved in interscholastic athletics and requires Parents/Guardian's to carry medical insurance that covers their athlete in the event of an injury or accident. HCHS will make every effort to make every sport/activity as safe as possible. Players can help make the game safe by not intentionally using techniques which are illegal and which can cause serious injury.

**Family:**

We have read the information stated in the Hononegah Community High School Parent/Athletic Handbook and we agree to adhere to all rules and regulations. We also understand by signing this document we will abide by the terms and conditions of the Hononegah Community High School Substance Use and Drug Testing Policy.

X	X
Student Signature	Parent/Guardian Signature
Date	Date

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