

VISTA UNIFIED SCHOOL DISTRICT

Athletic Screening History & Physical Exam

Please indicate: [] Mission Vista HS [] Rancho Buena Vista HS [] Vista HS

Student Name:	Student ID #:
Address:	Date of Birth:
City/Zip:	Graduating Year:
Home Phone:	Parent Name / Cell # :
Emergency Contact / Phone:	Parent Name / Cell # :

EXPLANATION OF SCREENING PHYSICAL

I realize that the medical evaluations performed are only screens in order to evaluate general health, to disclose existing problems, and to determine my son/daughter's dynamic ability to participate in a given sport so that obvious conditions which might be damaged or aggravated by competitive sports can be found, evaluated and treated so as to prevent further injury. This examination does not guarantee against injury.

Parents Initials _____

AWARENESS OF RISK

STUDENT AND PARENT - I am aware that playing/practicing sports can be a dangerous activity involving many risks of injury. I understand that the risks of participation include, but are not limited to, death, serious neck and spinal cord injuries that may result in complete or partial paralysis, brain damage, serious internal injury to virtually any internal organs, bones, joints, muscles, tendons, or any other aspect of the skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being. I understand that the risks of participant may result not only in serious injury, but in impairment of my future ability to earn a living, to engage in other business, social and recreational activities, and generally to enjoy a good life. Because of the dangers of participant in sports, I recognize the importance of following coaches' instructions regarding playing techniques, training, equipment and other team rules, etc. both in competition and practice and agree to obey such instructions.

Parents Initials _____

PERMISSION FOR TREATMENT

I hereby grant permission to the Athletic Trainer, Team Physicians and those professional personnel designated by Vista Unified School District to treat my son/daughter in the event of an injury. In the event of a serious injury, if I am unable to give my consent at that time, this consent is to include any and all emergency procedures deemed necessary by the attending emergency personnel. I also understand that in the event of injury, every reasonable attempt will be made to contact me prior to securing medical treatment beyond basic first-aid.

Parents Initials _____

PROOF OF INSURANCE

In compliance with California Education Code 32221, I certify that there is in effect at this time insurance coverage for medical expenses resulting from bodily injury of at least \$5,000 for my son/daughter, and that this coverage will remain in effect throughout the time that he/she participates in sports. I also give my permission for the above named student to participate in sports, including regularly scheduled trips by supervision school transportation.

Parents Initials _____ Insurance Carrier _____ Policy # _____

I have read the above statement, EXPLANATION OF SCREENING PHYSICAL, AWARENESS OF RISKS, and PERMISSION FOR TREATMENT, and understand them fully and agree/consent to their contents.

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____

Health History - Please answer the following in the check box provided. Explain "yes" answers in the box below.

1. Have you ever been hospitalized (overnight)? Yes No
2. Have you ever had surgery? Yes No
3. Are you currently taking medication? Yes No
4. Do you have any allergies (medicines, pollen, bees)? Yes No
5. Have you ever passed out during exercise? (Not from heat) Yes No
6. Have you ever been dizzy during exercise? (Not from heat) Yes No
7. Have you ever had chest pain? Yes No
8. Do you tire more quickly than your friends during exercise? Yes No
9. Have you ever had high blood pressure? Yes No
10. Have you ever been told you had a heart murmur? Yes No
11. Have you ever had racing of your heart or skipped beats? Yes No
12. Has anyone in your family died of heart problems or a sudden death before age 40? Yes No
13. Does anyone in your family have Marfan's Syndrome? Yes No
14. Do you have any skin problems (itching, rashes, breaking out)? Yes No
15. Have you ever had a head injury? Yes No
 Have you ever been knocked out? Yes No
 Have you ever had a seizure? Yes No
 Have you ever had a burn/stinger? (Pain from neck to arm) Yes No
16. Have you ever had heat cramps? Yes No
 Have you ever been dizzy or passed out in the heat? Yes No
17. Do you use special pads or orthotic braces? Yes No
18. Have you ever injured (broken/fractured, sprained, and dislocated)?
 Hand / fingers Shoulder Hip Shin / calf Wrist / forearm Neck Thigh
 Ankle Elbow Chest/ribs Knee Foot / toes Upper arm Back
 Stress fractures?
19. Have you ever had?
 Mononucleosis Diabetes Hepatitis Headaches (frequent) Eye/ear injuries
 Tuberculosis Measles Hernia(s) Asthma Ulcers
 Sickle cell trait/disease
20. When was your last tetanus shot? _____
21. About your weight: Do you think you are ... just Right? too Heavy? too Thin / Light?
 For females: Are your periods Regular/monthly? Irregular / skip months?
- When was your first period and how old were you? _____ When was your last period? _____

Please ask the doctor to address any questions that you may have. [All discussions are kept confidential.]

Please Explain and "YES" answers here:

Student Name _____

Circle the sport(s) you will be participating in:

Baseball	Basketball	Cheerleading	Cross Country	Field Hockey
Football	Golf	Soccer	Softball	Swimming
Track/Field	Tennis	Volleyball	Water Polo	Wrestling

Physical Examination

(To be completed by Medical Personnel)

Height _____

Blood Pressure _____
(sitting, left arm)

Vision (optional)

Left eye 20 / _____

Right eye 20 / _____

Both eyes 20 / _____

Weight _____

Pulse _____

with / without glasses

1. Skin	
2. Head	
3. Eyes (PERLA, EOMI, Fundi)	
4. Ears nose, throat	
5. Neck	
6. Lymphatic	
7. Respiratory	
8. Cardiovascular Heart (murmurs)?	
9. Abdomen	
10. Extremities	
11. Neurological Reflexes	
12. Orthopedic	
Cervical spine/back	
Arms/elbows/wrist/hands	
Hips	
Knees	
Ankles/feet	

√ = within normal limits

+ = see comments

X= omitted

Comments / Recommendations:

Student Name _____

MEDICAL CLEARANCE

(As appropriate for age and development)

- Full contact/collision level (full, unrestricted participation)
- Limited contact / impact
- Non-contact: strenuous
- Non-contact: non-strenuous
- Clearance deferred or no participation at this time because:

Needs clearance by specialist

Orthopedist Cardiologist

Other: _____

Needs to complete rehabilitation for current condition(s) prior to participation

Physician's Statement:

(Student's name) _____ was examined by me on _____
and found physically fit to engage in high school athletics. Results are to encourage, but in no way
guarantee the fitness and safety of this athlete.

Practitioner signature: _____ Date: _____
M.D. / D.O. / N.P. / P.A. / D.C.

Do not sign without student's name filled in

Physician's Office Stamp HERE (REQUIRED)

Permission for Medical Treatment

Sport and Level

I hereby grant permission to the Athletic Training Staff (Athletic Trainer, Coach, Paramedics, and/or the Emergency Room Physician) at Mission Vista High School to evaluate my son/daughter if any injury or illness should occur during a team practice or game. I understand that if an injury/ illness should occur the Athletic Training Staff would give me the necessary recommendations, referrals or course of treatment. I also understand that in a medical emergency should occur every effort would be made by the Athletic Training Staff to contact me with the information that I give below.

(Please Print Clearly)

	Parent Signature	Date
Student's First and Last Name	Age	Grade
Mother's Name or Guardian	Father's Name or Guardian	
Mother's Cell Phone or Guardian	Father's Cell Phone or Guardian	
Student's Home Address	City	Home Phone Number
1. <u>Non Parent</u> Emergency Contact	Relationship	Phone Number
2. <u>Non Parent</u> Emergency Contact	Relationship	Phone Number
Insurance Carrier	Policy Number	Student's Birthdate

Health History

Medical Conditions – If answered “yes,” please describe.

Kidney injures/ Heart Conditions/ Diabetes	yes	no	
Contact Lenses / Glasses	yes	no	
Asthma	yes	no	
(If yes, medication being used at this time)			
** athlete may supply athletic trainer with an inhaler**			
Allergies	yes	no	
(Please list all – environmental or to medications)			

Medications currently using:

Any other Concerns:

Mission Vista High School 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:

- Headaches
- “Pressure in head”
- Nausea or vomiting
- Neck pain
- Balance problems or dizziness
- Blurred, double, or fuzzy vision
- Sensitivity to light or noise
- Feeling sluggish or slowed down
- Feeling foggy or groggy
- Drowsiness
- Change in sleep patterns
- Amnesia
- “Don’t feel right”
- Fatigue or low energy
- Sadness
- Nervousness or anxiety
- Irritability
- More emotional
- Confusion
- Concentration or memory problems (forgetting game plays)
- Repeating the same question/comment

Signs observed by teammates, parents and coaches include:

- Appears dazed
- Vacant facial expression
- Confused about assignment
- Forgets plays
- Is unsure of game, score, or opponent
- Moves clumsily or displays incoordination
- Answers questions slowly
- Slurred speech
- Shows behavior or personality changes
- Can’t recall events prior to hit
- Can’t recall events after hit
- Seizures or convulsions
- Any change in typical behavior or personality
- Loses consciousness

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 athlete 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 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. The new CIF Bylaw 313 now requires implementation of long and well-established return to play concussion guidelines that have been recommended for several years:

“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 and for the remainder of the day.”

and

“A student-athlete who has been removed 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 received written clearance to return to play from that health care provider”.

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

For current and up-to-date information on concussions you can go to:

<http://www.cdc.gov/ConcussionInYouthSports/>

Student-athlete Name Printed

Student-athlete Signature

Date

Parent or Legal Guardian Printed

Parent or Legal Guardian Signature

Date

Keep Their Heart in the Game

A Sudden Cardiac Arrest Information Sheet for Athletes and Parents/Guardians

What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. SCA is NOT a heart attack. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the victim to collapse. The malfunction is caused by a congenital or genetic defect in the heart's structure.

How common is sudden cardiac arrest in the United States?

As the leading cause of death in the U.S., there are more than 300,000 cardiac arrests outside hospitals each year, with nine out of 10 resulting in death. Thousands of sudden cardiac arrests occur among youth, as it is the #2 cause of death under 25 and the #1 killer of student athletes during exercise.

Who is at risk for sudden cardiac arrest?

SCA is more likely to occur during exercise or physical activity, so student-athletes are at greater risk. While a heart condition may have no warning signs, studies show that many young people do have symptoms but neglect to tell an adult. This may be because they are embarrassed, they do not want to jeopardize their playing time, they mistakenly think they're out of shape and need to train harder, or they simply ignore the symptoms, assuming they will "just go away." Additionally, some health history factors increase the risk of SCA.

**FAINTING
is the
#1 SYMPTOM
OF A HEART CONDITION**

What should you do if your student-athlete is experiencing any of these symptoms?

We need to let student-athletes know that if they experience any SCA-related symptoms it is crucial to alert an adult and get follow-up care as soon as possible with a primary care physician. If the athlete has any of the SCA risk factors, these should also be discussed with a doctor to determine if further testing is needed. Wait for your doctor's feedback before returning to play, and alert your coach, trainer and school nurse about any diagnosed conditions.

What is an AED?

An automated external defibrillator (AED) is the only way to save a sudden cardiac arrest victim. An AED is a portable, user-friendly device that automatically diagnoses potentially life-threatening heart rhythms and delivers an electric shock to restore normal rhythm. Anyone can operate an AED, regardless of training. Simple audio direction instructs the rescuer when to press a button to deliver the shock, while other AEDs provide an automatic shock if a fatal heart rhythm is detected. A rescuer cannot accidentally hurt a victim with an AED—quick action can only help. AEDs are designed to only shock victims whose hearts need to be restored to a healthy rhythm. Check with your school for locations of on-campus AEDs.



The Cardiac Chain of Survival

On average it takes EMS teams up to 12 minutes to arrive to a cardiac emergency. Every minute delay in attending to a sudden cardiac arrest victim decreases the chance of survival by 10%. Everyone should be prepared to take action in the first minutes of collapse.

Early Recognition of Sudden Cardiac Arrest



Collapsed and unresponsive.
Gasping, gurgling, snorting, moaning or labored breathing noises.
Seizure-like activity.

Early Access to 9-1-1



Confirm unresponsiveness.
Call 9-1-1 and follow emergency dispatcher's instructions.
Call any on-site Emergency Responders.

Early CPR



Begin cardiopulmonary resuscitation (CPR) immediately. Hands-only CPR involves fast and continual two-inch chest compressions—about 100 per minute.

Early Defibrillation



Immediately retrieve and use an automated external defibrillator (AED) as soon as possible to restore the heart to its normal rhythm. Mobile AED units have step-by-step instructions for a bystander to use in an emergency situation.

Early Advanced Care



Emergency Medical Services (EMS) Responders begin advanced life support including additional resuscitative measures and transfer to a hospital.

Keep Their Heart in the Game

Recognize the Warning Signs & Risk Factors of Sudden Cardiac Arrest (SCA)

Tell Your Coach and Consult Your Doctor if These Conditions are Present in Your Student-Athlete

Potential Indicators That SCA May Occur

- Fainting or seizure, especially during or right after exercise
- Fainting repeatedly or with excitement or startle
- Excessive shortness of breath during exercise
- Racing or fluttering heart palpitations or irregular heartbeat
- Repeated dizziness or lightheadedness
- Chest pain or discomfort with exercise
- Excessive, unexpected fatigue during or after exercise

Factors That Increase the Risk of SCA

- Family history of known heart abnormalities or sudden death before age 50
- Specific family history of Long QT Syndrome, Brugada Syndrome, Hypertrophic Cardiomyopathy, or Arrhythmogenic Right Ventricular Dysplasia (ARVD)
- Family members with unexplained fainting, seizures, drowning or near drowning or car accidents
- Known structural heart abnormality, repaired or unrepaired
- Use of drugs, such as cocaine, inhalants, "recreational" drugs, excessive energy drinks or performance-enhancing supplements

What is CIF doing to help protect student-athletes?

CIF amended its bylaws to include language that adds SCA training to coach certification and practice and game protocol that empowers coaches to remove from play a student-athlete who exhibits fainting—the number one warning sign of a potential heart condition. A student-athlete who has been removed from play after displaying signs or symptoms associated with SCA may not return to play until he or she is evaluated and cleared by a licensed health care provider. Parents, guardians and caregivers are urged to dialogue with student-athletes about their heart health and everyone associated with high school sports should be familiar with the cardiac chain of survival so they are prepared in the event of a cardiac emergency.

I have reviewed and understand the symptoms and warning signs of SCA and the new CIF protocol to incorporate SCA prevention strategies into my student's sports program.

STUDENT-ATHLETE SIGNATURE

PRINT STUDENT-ATHLETE'S NAME

DATE

PARENT/GUARDIAN SIGNATURE

PRINT PARENT/GUARDIAN'S NAME

DATE

For more information about Sudden Cardiac Arrest visit

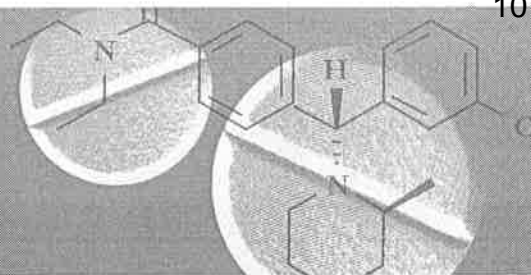
California Interscholastic Federation
<http://www.cifstate.org>

Eric Paredes Save A Life Foundation
<http://www.epsavealife.org>

National Federation of High Schools
 (20-minute training video)
<https://nfhslearn.com/courses/61032>



PRESCRIPTION OPIOIDS: WHAT YOU NEED TO KNOW



Prescription opioids can be used to help relieve moderate-to-severe pain and are often prescribed following a surgery or injury, or for certain health conditions. These medications can be an important part of treatment but also come with serious risks. It is important to work with your health care provider to make sure you are getting the safest, most effective care.

WHAT ARE THE RISKS AND SIDE EFFECTS OF OPIOID USE?

Prescription opioids carry serious risks of addiction and overdose, especially with prolonged use. An opioid overdose, often marked by slowed breathing, can cause sudden death. The use of prescription opioids can have a number of side effects as well, even when taken as directed:

- Tolerance—meaning you might need to take more of a medication for the same pain relief
- Physical dependence—meaning you have symptoms of withdrawal when a medication is stopped
- Increased sensitivity to pain
- Constipation
- Nausea, vomiting, and dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Low levels of testosterone that can result in lower sex drive, energy, and strength
- Itching and sweating

As many as
1 in 4
PEOPLE*



receiving prescription opioids long term in a primary care setting struggles with addiction.

* Findings from one study

RISKS ARE GREATER WITH:

- History of drug misuse, substance use disorder, or overdose
- Mental health conditions (such as depression or anxiety)
- Sleep apnea
- Older age (65 years or older)
- Pregnancy

Avoid alcohol while taking prescription opioids. Also, unless specifically advised by your health care provider, medications to avoid include:

- Benzodiazepines (such as Xanax or Valium)
- Muscle relaxants (such as Soma or Flexeril)
- Hypnotics (such as Ambien or Lunesta)
- Other prescription opioids



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

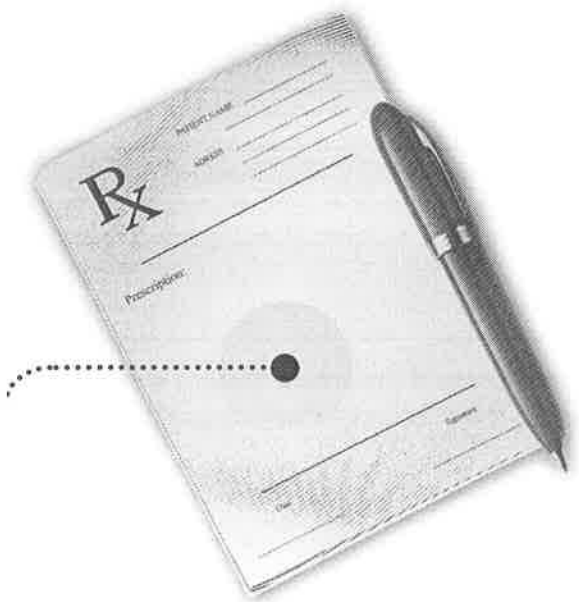


American Hospital
Association®

KNOW YOUR OPTIONS

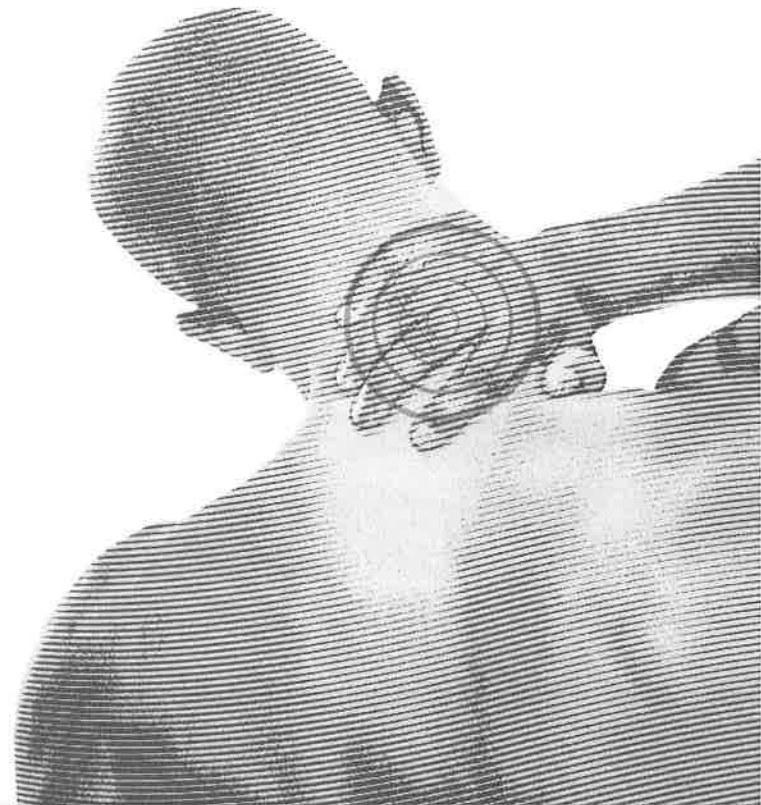
Talk to your health care provider about ways to manage your pain that don't involve prescription opioids. Some of these options **may actually work better** and have fewer risks and side effects. Options may include:

- ❑ Pain relievers such as acetaminophen, ibuprofen, and naproxen
- ❑ Some medications that are also used for depression or seizures
- ❑ Physical therapy and exercise
- ❑ Cognitive behavioral therapy, a psychological, goal-directed approach, in which patients learn how to modify physical, behavioral, and emotional triggers of pain and stress.



Be Informed! ←

Make sure you know the name of your medication, how much and how often to take it, and its potential risks & side effects.



IF YOU ARE PRESCRIBED OPIOIDS FOR PAIN:

- ❑ Never take opioids in greater amounts or more often than prescribed.
- ❑ Follow up with your primary health care provider within ___ days.
 - Work together to create a plan on how to manage your pain.
 - Talk about ways to help manage your pain that don't involve prescription opioids.
 - Talk about any and all concerns and side effects.
- ❑ Help prevent misuse and abuse.
 - Never sell or share prescription opioids.
 - Never use another person's prescription opioids.
- ❑ Store prescription opioids in a secure place and out of reach of others (this may include visitors, children, friends, and family).
- ❑ Safely dispose of unused prescription opioids: Find your community drug take-back program or your pharmacy mail-back program, or flush them down the toilet, following guidance from the Food and Drug Administration (www.fda.gov/Drugs/ResourcesForYou).
- ❑ Visit www.cdc.gov/drugoverdose to learn about the risks of opioid abuse and overdose.
- ❑ If you believe you may be struggling with addiction, tell your health care provider and ask for guidance or call SAMHSA's National Helpline at 1-800-662-HELP.

VISTA UNIFIED SCHOOL DISTRICT

ATHLETIC PARTICIPATION SIGNATURE FORM

STUDENT NAME: _____ (Please print)

GRADE: _____ SPORT(s): _____

VISTA UNIFIED SCHOOL ATHLETIC HANDBOOK

I have reviewed and agree to abide by the guidelines/policies in the Vista Unified School District Athletic Handbook available on each High School's Website under *Athletics*. By signing below, I acknowledge that it is my responsibility to read and understand these rules and discuss them with my parent/guardians.

ATHLETIC POLICY AGAINST HAZING

Vista Unified School District strives to maintain a healthy athletic program in which all students feel safe, welcome and proud of the school and the athletic programs they represent. I understand that hazing of any kind is not allowed on this campus and in the athletic program. This includes mental, verbal and physical acts. I further understand that it is my duty to report any acts of hazing that I see to a coach or administrator on campus. By signing below, I agree to uphold this District policy and understand that any violation will result in my immediate suspension from athletics and further disciplinary action as outlined in District policy and procedures.

ETHICS INSPO RTS POLICY

By signing below, I accept and understand the Policy Statement, Code of Ethics, The Pillars and Principles of Pursuing Victory With Honor, and the Violations, Minimum Penalties, and Appeal Process of the CIF-San Diego Section ETHICS IN SPORTS Policy. I agree to abide by this policy while participating and/or spectating at CIFSDS athletic events regardless of contest site or jurisdiction.

* ALL NEW STUDENTS TO VISTA UNIFIED SCHOOL DISTRICT *

Please Circle one: Mission Vista H.S. Rancho Buena Vista H.S. Vista H.S.

INCOMING 9TH GRADERS AND ALL TRANSFER STUDENTS PLEASE COMPLETE THIS SECTION.

CIF ADVISEMENTS RE: Bylaw 510

State CIF Bylaws require that all information provided in regard to any aspect of student eligibility to participate in athletics must be true, correct, accurate, and complete. State CIF Bylaws also require that parents, students, coaches and schools must disclose any pre-enrollment contact of any kind whatsoever with the parent or student during the 24 months prior to enrollment in the school.

- [] There has been no pre-enrollment contact of any kind whatsoever during the previous 24 months with anyone at or associated with the school or its athletic programs.
- [] There has been pre-enrollment contact during the previous 24 months with individuals at or association with the school and its athletic programs. A true, correct, accurate, and complete disclosure of that contact is attached to this form.

Student's Name (printed)

Parent/Guardian Name (Printed)

Student's Signature

Date

Parent/Guardian Signature

Date

Vista Unified School District
ATHLETIC HANDBOOK
 and
 San Diego Section C.I.F. Code of Ethics

Signature Page

I have read a copy of the *Vista Unified School District Athletic Handbook & San Diego Section C.I.F. Code of Ethics.*

I understand it is my responsibility as the student athlete to read/understand these rules, take them home, and discuss them with my parent/guardian(s).

- Yes, I will allow my name and photograph to be posted on the school's website in regards to athletics.
- No, I do not wish to have my name and photograph posted on the School's website in regards to athletics.

 Student Name (printed)

 Parent Name (printed)

 Student Signature

 Parent Signature

 Date

 Date