Coast Union High School Sports Application

Students interested in participating in CUHS sports must submit the attached forms to the athletic department before attending any practice or competing in any athletic event. No student shall practice or compete without authorization from the Athletic Director. No exceptions!

The attached forms must be read, completed and signed by the parent/guardian and the student-athlete where applicable. Incomplete forms will not be accepted.

Students must also have no outstanding financial obligations (uniforms returned) and must be academically eligible (2.0 or higher with F).

The following forms are for you to read and keep for your reference:

1. A Fact Sheet for High School Parents (Heads Up Concussion)
2. A Fact Sheet for High School Athletes (Heads Up Concussion)
3. Prescription Opioid: What you need to know.

The following forms are to be read, completed, signed and returned to Megan Swanlund in the Athletic training room or to the main office:

1. Student Athlete Information & Medical Authorization Form
2. Insurance Coverage Form
3. Voluntary Activities Participation Form
4. Concussion Information Acknowledgement Form
5. CIF Southern Section Code of Ethics Form
6. Preparticipation Physical Evaluation- History Form
7. Preparticipation Physical Evaluation-Physical Examination Form

Coast Union High School
Student Athlete Information & Medical Authorization

All information is required and must be completed by the **parent or guardian of the student**. All signatures are required.

Use Black or blue ink and print neatly.

Athletes Full Name: _____ Home Phone: _____
First MI Last

Physical Address: _____
Street Address City Zip Code

Date of Birth_____ Age_____ Grade_____

Mother's Name:_____ Home Phone_____ Work #_____ Cell #_____

Father's Name:_____ Home Phone_____ Work #_____ Cell #_____

In an emergency if the parent(s) cannot be reached, notify:

Name:_____ Relationship_____ Home #_____ Work #_____

Name:_____ Relationship_____ Home #_____ Work #_____

Are you an Inter-District Student? Have you ever played for a team at another high school? Yes____ No_____
If yes, where? _____ What sport? _____

MEDICAL AUTHORIZATION

As the parent or legal guardian of the above listed athlete, I hereby consent to any hospital, emergency center, doctor, nurse, and/or paramedic, authorization to grant treatment to my child, provided that the hospital is unable to reach a parent or guardian at the above listed phone numbers. Further, should the attending physician determine, after examination, that life-saving procedures may be necessary; permission is hereby extended to the above parties to grant the same. Additionally, I agree to hold harmless Coast Unified School District personnel and Coast Unified School District Board of Trustees by my action of granting said permission.

_____ _____ _____
Signature of Parent/Guardian Printed Name of Parent/Guardian Date

Consent to Treat

I, the Parent/Guardian of the above name student, understand that my student-athlete may be injured while participating in school sponsored athletics. I hereby grant authorization to the Sports Medicine Team, comprised by but not limited to the athletic trainer, approved physical therapist, physicians to administer any preventative, first aid or emergency treatment to evaluate and examine my student-athlete with the purpose of attempting to relieve and treat any injuries received while participating at Coast Union High School. I understand that there is a possibility of complications and unforeseen consequences in any medical treatment, and I assume any such risk on behalf of myself and said minor. I acknowledge that no warranty is being made as to the results of any treatment.

_____ _____ _____
Signature of Parent/Guardian Printed Name of Parent/Guardian Date

Authorization to Release and Consent to Exchange Medical Information

'I, hereby authorize/consent for the Sports Medicine team to release information regarding my student athlete's protected health information (PHI) and related information regarding an injury or illness which may occur during the student-athlete's training for and participation in athletics to any coach, athletic director, or school official in connection with my student's participation in interscholastic sports. This protected health information may concern the student athlete's medical status, medical condition, injuries, prognosis, diagnosis, athlete participation status and related personally identifiable health information. This protected information may be released to other healthcare providers, hospital and/or medical clinics and laboratories, athletic coaches, athletic trainers, medical insurance coordinators, athletic and or school administrators, and officials of the student athlete's sport for the purpose of maintaining continuity of care.

_____ _____ _____
Signature of Parent/Guardian Printed Name of Parent/Guardian Date

Insurance Coverage

Ca. ED. Code requires insurance coverage on all students who wish to participate in interscholastic sports.

Self-Insured School of California (SISC) provides a Self-Insured Basic Plan that provides up to $2,500 for accidental injury, at no cost to you, while attending school and participating in school sponsored activities and athletics. If any other health insurance policy is held on behalf of a Coast Union High School student, SISC coverage is secondary. For students not covered by any other health insurance program, the SISC insurance will be primary.

High school tackle football is excluded from this plan. If your child is injured while participating in high school tackle football SISC's Self-Insured Basic Plan will not provide any financial compensation for that injury. Many health insurance companies exclude Tackle Football coverage. **Please read your policy, you may need additional coverage.**

SISC Tackle Football Coverage

SISC Tackle Football Coverage can be purchased separately, and provides protection from an accident which occurs while practicing for, participating in a regularly scheduled and school sponsored tackle football game or traveling as a team member on school transportation to or from games not on the school grounds.

Student-Athlete Name:_____

____ No, I do not want to purchase the SISC Tackle Football Coverage. I have an Insurance Policy that provides adequate coverage for Tackle Football, I also agree to indemnify and hold harmless Coast Unified School District form any and all responsibility or liability arising out of or in any way related to the requirement under the aforementioned code section to provide insurance coverage for the above named student.

____ Yes, I want to purchase the SISC Tackle Football Coverage.

Supplemental Student Accident Coverage

SISC also offers Supplemental Student Accident Coverage for those students that may participate in other sports, instead of, or in addition to tackle football.

____ Yes, I want to purchase the SISC Supplemental Student Accident Coverage

____ No, I do not want to purchase the SISC Supplemental Student Accident Coverage

Type of coverage	Maximum Benefit	Yearly Premium Cost	Notes
Basic	**$2,500**	**free**	**Does not cover football**
Supplemental	**$25,000**	**$25.00**	**Does not cover football**
Tackle Football	**$15,000**	**$60.00**	**Covers tackle football**

*additional details can be found in SISC brochures.

Additional Insurance Information

Please do not assume that your child does not qualify for health insurance. Some students may qualify to enroll in no-cost or low-cost local, state or federally sponsored health insurance programs. If you are unsure, information about these programs may be obtained by calling the programs below:

1. Healthy Families Program: (888)747-1222
2. Medi-Cal Program: (888)880-5305
3. SISC Supplemental Insurance Program: (661)636-4736
   Contact: Elsa Lara

Coast Unified School District

Athletics Activities Participation Form

Acknowledgement and Assumption of Potential Risk

I understand and acknowledge that these activities, by their nature, pose the potential risk of serious injury/illness to individuals who participate in such activities.

I understand and acknowledge that some of the injuries/illnesses that may result from participating in these activities include, but are not limited to the following:

1. sprains/strains
2. Fractures
3. Unconsciousness
4. Head and/or spine injuries
5. Traumatic brain injury
6. Paralysis
7. Loss of eyesight
8. Communicable diseases
9. Death

I understand and acknowledge that participation in these activities is completely voluntary and as such is not required by the District for course credit or for completion of graduation requirements.

I understand and acknowledge that in order to participate in these activities, I and my child agree to assume liability and responsibility for any and all potential risk that may be associated with participation in such activities.

I understand, acknowledge, and agree that the Coast Unified School District, its employees, officers, agents, or volunteers shall not be liable and I hereby waive, release and discharge them from any future claims, demands, obligations, or causes of action for any injury/illness or property damage suffered by my child arising as a result of engaging or receiving instruction in said activities or any activity that is incidental thereto.

I, _____(Student) acknowledge that I have carefully read this "Athletics Activities Participation Form" and that I understand and agree to its terms. I realize that there are risks involved in my participation that include a full range of injuries, from minor to severe. I recognize the possibility that I might die, become paralyzed, or suffer other permanent disabilities as a result of my participation. I agree to accept this risk as a condition of my participation.

Signature of student: _____Date: _____

I, _____ (parent/guardian), acknowledge that I have carefully read this "Voluntary Activities Participation Form" and that I understand and agree to its terms. I realize that there are risks involved in my child's participation that includes a full range of injuries, from minor to severe. I recognize the possibility that my child might die, become paralyzed, or suffer other permanent disabilities as a result of their participation. I agree to accept this risk as a condition of their participation.

Signature of Parent/Guardian: _____Date: _____

Performance Enhancing Drugs

Coast Unified School District prohibits the use of any Androgenic/ Anabolic Steroids. As a student-athlete, I will not use or engage in the use of Steroids or any other performance enhancing drug that has not been medically prescribed for me by a fully licensed medical physician.

Signature of Student Athlete: _____Date: _____

Signature of Parent/Guardian_____ Date: _____

Consent of Search

I acknowledge that, as the parent/ guardian of the above-named student, I have taken steps to insure items (backpack, ice chests, sports bags, etc.) brought to any athletic event by my son/daughter are appropriate. Further, I agree that as a team member my son's /daughter's carry-on items may be searched at any athletic event that requires district transportation. Failure of the student or parent to consent to such search will result in the student's forfeiture to travel and to participate in the athletic event.

Signature of Student Athlete: _____Date: _____

Signature of Parent/Guardian: _____ Date: _____

CUHS Student Handbook

I have read and understand the contents of the CUHS Student Handbook and will abide by the rules set forth by the Administration of Coast USD.
(*CUHS Student Handbook can be found at: https://coastunion.coastusd.org/students/handbook*)

Signature of Student Athlete: _____Date: _____

Signature of Parent/Guardian: _____ Date: _____

CONCUSSION INFORMATION ACKNOWLEDGEMENT FORM

Head Injury Management Protocol

A.B. 2127 and CIF Bylaws mandated a MINIMUM timeline, but medical experts recognize that many adolescent concussion patients may take much longer to recover. Always be cautious as returning to practice and play too quickly may have catastrophic consequences.

1. Concussion education for coaches, parents and students will be made available throughout the school year. Information will include recognition of concussion, and the importance of reporting signs and symptoms to a healthcare provider, parent and coach.
2. ImPACT testing will be utilized to establish baseline cognitive scores (football, basketball, & soccer), and again in the event of a concussion.
    a. Baseline testing will be done prior to contact practices at the beginning of the athletic season. Baseline testing is good for two years.
    b. Per the IMPACT company's guidelines, post-concussion testing is recommended within 48-72 hours after injury. Test is repeated once the athlete is asymptomatic, or at weekly intervals. If the case is mild and return to play is imminent, the test may be performed twice in a week, but never more than this.
    c. Results may be interpreted by team physician, family physician, neurologist or neuropsychologist
    d. If the athlete does not have a baseline on record, they may still be given a post-injury test, as results can be compared to ImPACT's large normative database.
3. Any athlete suspected of having a concussion will be removed from play immediately, and not allowed to return to play the same day.
4. All athletes sustaining any type of head injury, regardless of severity, must be evaluated and the SCAT6 Evaluation form must be completed
5. Each athlete with suspected concussion also must be released to a parent or adult who will sign the Home Care Instruction form.
6. Testing and Return to sport guidelines will follow the 6th *International Conference on Concussion in Sport Consensus Statement* and California Education Code, Section 49475, and CIF Bylaws. In order to be returned to play, the athlete must have **no physical symptoms**, **no cognitive symptoms**, and a **written MD/DO clearance**.
7. Athletic Trainer will follow up daily with injured athlete, utilizing the Graded Symptom Checklist
8. All notes, including initial evaluation, parent/MD communication will be documented.
9. Graded Return to Sport Guidelines will be followed in all cases of confirmed head injury:
    - At least one day at each phase.
    - If no return of symptoms during, or day after, may progress to the next phase.
    - If any physical or cognitive symptoms occur, during or day after, go back to the previous phase.
    - Minimum time to return to full contact = 7 days, per state law.

Please keep "A Fact Sheet for High School Athletes" & "A Fact Sheet for High School Parents" for your reference.

I have read and understand "A Fact Sheet for High School Athletes" on concussion and talked with my parents or legal guardian about what to do if I have a concussion or other serious brain injury.

Athlete Name Printed:_____Date: _____

Athlete Signature:_____

I have read and understand "A Fact Sheet for High School Parents" on concussion with my child and talked about what to do if they have a concussion or other serious brain injury.

Parent or Legal Guardian Name Printed: _____Date: _____

Parent or Legal Guardian Signature:_____

Revised 3/2024

10932 Pine Street
Los Alamitos, California 90720

562-493-9500
www.cifss.org

Code of Ethics – Athletes

DO NOT SEND TO CIF SOUTHERN SECTION
A copy of this form must be kept on file in the athletic director's office at the local high school.

Athletics is an integral part of the school's total educational program. All school activities, curricular and extra-curricular, in the classroom and on the playing field, must be congruent with the school's stated goals and objectives established for the intellectual, physical, social and moral development of its students. It is within this context that the following Code of Ethics is presented.

As an athlete, I understand that it is my responsibility to:

1. Place academic achievement as the highest priority.
2. Show respect for teammates, opponents, officials and coaches.
3. Respect the integrity and judgment of game officials.
4. Exhibit fair play, sportsmanship and proper conduct on and off the playing field.
5. Maintain a high level of safety awareness.
6. Refrain from the use of profanity, vulgarity and other offensive language and gestures.
7. Adhere to the established rules and standards of the game to be played.
8. Respect all equipment and use it safely and appropriately.
9. Refrain from the use of alcohol, tobacco, illegal and non-prescriptive drugs, anabolic steroids or any substance to increase physical development or performance that is not approved by the United States Food and Drug Administration, Surgeon General of the United States or American Medical Association.
10. Know and follow all state, section and school athletic rules and regulations as they pertain to eligibility and sports participation.
11. Win with character, lose with dignity.

As a condition of membership in the CIF, all schools shall adopt policies prohibiting the use and abuse of androgenic/anabolic steroids. All member schools shall have participating students and their parents, legal guardian/caregiver agree that the athlete will not use steroids without the written prescription of a fully licensed physician (as recognized by the AMA) to treat a medical condition (Article 503.I).

By signing below, both the participating student athlete and the parents, legal guardian/caregiver hereby agree that the student shall not use androgenic/anabolic steroids without the written prescription of a fully licensed physician (as recognized by the AMA) to treat a medical condition. We recognize that under CIF Bylaw 202, there could be penalties for false or fraudulent information. We also understand that the _____ _____ (school/school district name) policy regarding the use of illegal drugs will be enforced for any violations of these rules.

_____
Printed Name of Student Athlete

_____
Signature of Student Athlete Date

_____
Signature of Parent/Caregiver Date

Revised 7/7/23

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of 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

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
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)?		
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?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
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?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with 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?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
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 foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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HE0503

9-2681/0410

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____ Weight _____	☐ Male ☐ Female	
BP ____/____ (____/____) Pulse _____	Vision R 20/_____ L 20/_____	Corrected ☐ Y ☐ N
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[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ 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 examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice 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 parents. 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 (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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HE0503 9-2681/0410

A FACT SHEET FOR

High School Parents

CDC HEADS UP

SAFE BRAIN. STRONGER FUTURE.

This sheet has information to help protect your teens from concussion or other serious brain injury.

What is a concussion?

A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move quickly back and forth. This fast movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging the brain cells.

How can I help keep my teens safe?

Sports are a great way for teens to stay healthy and can help them do well in school. To help lower your teens' chances of getting a concussion or other serious brain injury, you should:

- Help create a culture of safety for the team.
  - > Work with their coach to teach ways to lower the chances of getting a concussion.
  - > Emphasize the importance of reporting concussions and taking time to recover from one.
  - > Ensure that they follow their coach's rules for safety and the rules of the sport.
  - > Tell your teens that you expect them to practice good sportsmanship at all time.
- When appropriate for the sport or activity, teach your teens that they must wear a helmet to lower the chances of the most serious types of brain or head injury. There is no "concussion-proof" helmet. Even with a helmet, it is important for teens to avoid hits to the head.

Talk with your teens about concussion.

Tell them to report their concussion symptoms to you and their coach right away.

How can I spot a possible concussion?

Teens who show or report one or more of the signs and symptoms listed below—or simply say they just "don't feel right" after a bump, blow, or jolt to the head or body—may have a concussion or other serious brain injury.

Signs observed by parents

- Appears dazed or stunned
- Is confused about events
- Answers questions slowly
- Repeats questions
- Can't recall events *prior* to the hit, bump, or fall
- Can't recall events *after* the hit, bump, or fall
- Loses consciousness (even briefly)
- Shows behavior or personality changes
- Forgets an instruction or assignment

Symptoms reported by teens

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Blurry or double vision
- Sensitivity to light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty concentrating or remembering
- Just not "feeling right" or "feeling down"



CONCUSSIONS AFFECT EACH TEEN DIFFERENTLY.

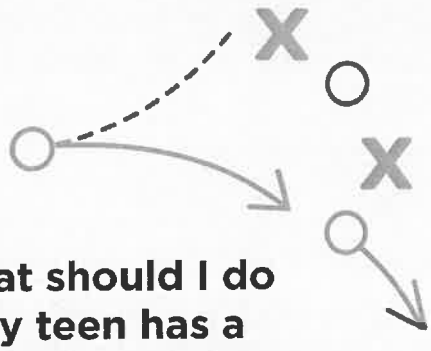
Although most teens with a concussion feel better within a couple of weeks, some will have symptoms for months or longer. Talk with your teens' healthcare provider if their concussion symptoms do not go away or if they get worse after they return to their regular activities. **Be sure to offer support during their recovery and allow them to stay connected with friends and others.**

What are some more serious danger signs to look out for?



In rare cases, a dangerous collection of blood (hematoma) may form on the brain after a bump, blow, or jolt to the head or body, and can squeeze the brain against the skull. Call 9-1-1 or take your teen to the emergency department right away if after a bump, blow, or jolt to the head or body he or she has one or more of these danger signs:

- One pupil (the black part in the middle of the eye) larger than the other
- Drowsiness or cannot be awakened
- A headache that gets worse and does not go away
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Difficulty recognizing people or places
- Increasing confusion, restlessness, or agitation
- Unusual behavior
- Loss of consciousness (even a brief loss of consciousness should be taken seriously)



What should I do if my teen has a possible concussion?

As a parent, if you think your teen may have a concussion, you should:

1. Remove your teen from play.
2. Keep your teen out of play the day of the injury. Your teen should be seen by a healthcare provider and only return to play with permission from a healthcare provider who is experienced in evaluating for concussion.
3. Ask your teen's healthcare provider for written instructions on helping your teen return to school. You can give the instructions to your teen's school nurse and teacher(s) and return-to-play instructions to the coach and/or athletic trainer.

Do not try to judge the severity of the injury yourself. Only a healthcare provider should assess a teen for a possible concussion. You may not know how serious the concussion is at first, and some symptoms may not show up for hours or days. A teen's return to school and sports should be a gradual process that is carefully managed and monitored by a healthcare provider.

Teens who continue to play while having concussion symptoms or who return to play too soon—while the brain is still healing—have a greater chance of getting another concussion. A repeat concussion that occurs while the brain is still healing from the first injury can be very serious and can affect a teen for a lifetime. It can even be fatal.

Revised August 2019

A FACT SHEET FOR

Athletes

CDC HEADS UP
SAFE BRAIN. STRONGER FUTURE.

This sheet has information to help you protect yourself from concussion or other serious brain injury and know what to do if a concussion occurs.

WHAT IS A CONCUSSION?

A concussion is a brain injury that affects how your brain works. It can happen when your brain gets bounced around in your skull after a fall or hit to the head.

What Should I Do If I Think I Have a Concussion?





Report It. Tell your coach, parent, and athletic trainer if you think you or one of your teammates may have a concussion. It's up to you to report your symptoms. Your coach and team are relying on you. Plus, you won't play your best if you are not feeling well.

Get Checked Out. If you think you have a concussion, do not return to play on the day of the injury. Only a healthcare provider can tell whether you have a concussion and when it is OK to return to school and play. The sooner you get checked out, the sooner you may be able to safely return to play.



Give Your Brain Time to Heal.
A concussion can make everyday activities, such as going to school, harder. You may need extra help getting back to your normal activities. Be sure to update your parents and doctor about how you are feeling.

Why Should I Tell My Coach and Parent About My Symptoms?



- Playing or practicing with a concussion is dangerous and can lead to a longer recovery.
- While your brain is still healing, you are much more likely to have another concussion. This can put you at risk for a more serious injury to your brain and can even be fatal.

GOOD TEAMMATES KNOW:
IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON.

cdc.gov/HEADSUP

How Can I Tell If I Have a Concussion?

You may have a concussion if you have any of these symptoms after a bump, blow, or jolt to the head or body:

- **Get a headache**
- **Feel dizzy, sluggish, or foggy**
- **Are bothered by light or noise**
- **Have double or blurry vision**
- **Vomit or feel sick to your stomach**
- **Have trouble focusing or problems remembering**
- **Feel more emotional or "down"**
- **Feel confused**
- **Have problems with sleep**

Concussion symptoms usually show up right away, but you might not notice that something "isn't right" for hours or days. A concussion feels different to each person, so it is important to tell your parents and doctor how you are feeling.

How Can I Help My Team?



Protect Your Brain.
Avoid hits to the head and follow the rules for safe and fair play to lower your chances of getting a concussion. Ask your coaches for more tips.



Be a Team Player.
You play an important role as part of a team. Encourage your teammates to report their symptoms and help them feel comfortable taking the time they need to get better.

The information provided in this document or through linkages to other sites is not a substitute for medical or professional care. Questions about diagnosis and treatment for concussion should be directed to a physician or other healthcare provider.

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To learn more, go to cdc.gov/HEADSUP

CDC HEADS UP

Intermountain® Healthcare

Prescription Opioids: What you need to know

Prescription opioids are medicines used to help relieve severe pain. They are often prescribed after a surgery or injury, or for certain health problems. Some common opioid medicines are **codeine, hydrocodone, methadone, morphine,** and **oxycodone.**

These medicines can be an important part of treatment. They also come with serious risks. It's important to work with your healthcare provider to make sure you are getting the safest, most effective care.

If you are prescribed opioids for pain:

- ☐ **Be informed.** Keep your prescription in the bottle it came in. Make sure you know:
  - The name of your medicine
  - How much to take
  - How often to take it
  - Side effects to watch out for, and when to call your doctor
- ☐ **Don't take more** pain medicine than your healthcare provider tells you to. **Don't take it more often** than they tell you to.
- ☐ **Follow up with your primary healthcare provider.**
  - 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 your concerns and side effects.
- ☐ **Ask your doctor or pharmacist if you should get a naloxone kit.** This can save your life if you have an accidental overdose.



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

- ☐ **Help prevent misuse and abuse.**
  - Never sell or share prescriptions opioids.
  - Never use another person's prescriptions opioids.
- ☐ **Lock up prescription opioids in a safe place and out of reach of others.** This may include visitors, children, friends, and family. Don't keep them in your medicine cabinet where anyone can find them.

Know your options

Talk to your healthcare provider about ways to manage your pain without opioids. Other methods **may actually work better** and have fewer risks and side effects. Options may include:

- ☐ Other pain relievers, such as acetaminophen (Tylenol), ibuprofen (Advil, Motrin), or naproxen
- ☐ Physical therapy and exercise
- ☐ Working with a therapist to help learn ways to change the triggers of pain and stress
- ☐ Some medicines that are also used for depression or seizures

What are the risks and side effects?

The biggest risks of prescription opioids are addiction and overdose. Risks are higher when you use them for a long time. An opioid overdose can cause **slowed breathing and sudden death.**

Prescription opioids can have side effects, even when taken as directed. These include:

- Constipation — this is the most common side effect
- Tolerance — the need to take more medicine for the same pain relief
- Physical dependence — having symptoms of withdrawal when you stop taking them
- Greater sensitivity to pain
- Nausea, vomiting, and dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Low levels of testosterone, which can lead to lower sex drive, energy, and strength
- Itching and sweating

Risks are greater if you:

- Have a history of drug misuse, substance abuse disorder, or overdose
- Are taking sedatives or you drink alcohol when taking prescription opioids
- Have a mental health condition, such as depression or anxiety
- Have sleep apnea
- Have a disability (increases your risk for falls)
- Are age 65 or older, are confused, have dementia or another mental disability
- Are pregnant

While you're taking prescription opioids:

- **Never use alcohol or street drugs.** Taking them together can kill you.
- Unless your doctor specifically says it's okay, **don't take any of these medicines:**
  - Benzodiazepines (such as Xanax or Valium)
  - Muscle relaxants (such as Soma or Flexeril)
  - Sleeping pills (such as Ambien or Lunesta)
  - Other prescription opioids
- Don't take any other pills or vitamins unless your doctor says it's okay.
- Don't drive or use machinery when impaired by opioid medication.

Safely dispose of unused prescription opioids

Find your community drug collection site at **UseOnlyAsDirected.org** or **www.UtahTakeBack.org** to safely dispose of leftover prescription opioids. It's best not to flush medications in the toilet as they can contaminate the water supply.

If you have leftover opioids, dispose of them safely.

Intermountain Community Pharmacies offer Rx Drop Boxes at all locations to safely throw away any leftover medications. Look for the big blue box at your neighborhood Intermountain Community Pharmacy.



The information in this fact sheet is adapted from *Prescription Opioids: What You Need to Know* written by The Centers for Disease Control and Prevention (CDC) and The American Hospital Association.

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