



DATE: 2020-2021 School Year  
TO: All Parents/Guardians  
FROM: Tom Argersinger, Head Administrator  
RE: Annual Physical Examination Requirements for Grades 9-12

Every Veritas student is required to have a physical evaluation and all completed paperwork returned to the school BEFORE the student can start the 2020-21 school year.

These students must use the state-mandated physical evaluation forms which are included in this packet and are also on the Veritas website. Please be diligent when visiting your healthcare provider to ensure that all forms are completed, including current medication orders, and most recent immunization records.

The following forms must be signed by *parent and physician*:

1. Physician's Medication Order Form
2. Universal Child Health Record – Use this form if student is NOT participating in any sports; **OR** Pre-Participation Physical Evaluation–Use this form if student will participate in SPORTS during the year
3. Asthma Treatment Plan – If applicable
4. Food Allergy Action Plan – If applicable

The following two forms for ALL students must be read and signed off by *parent and student*:

5. Sudden Cardiac Death in Young Athletes
6. Sports Related Concussion and Head Injury Fact Sheet and Acknowledgement

The following form must be completed if the student's exam took place within the last physical year (so you are unable to schedule another exam) and is more than 90 days old:

7. Health History Update Questionnaire – If applicable

Lastly, this form must be signed by *parent, physician, and student*:

8. Self-Medication Form – If applicable

As a reminder, all completed forms are due BEFORE the student starts the 2018-19 school year. This includes current medication orders with parental signature and a copy of the immunization record.

If you choose to make a religious exemption for immunizations, please create a letter to the school stating that it is due to religious beliefs, including student's name, reasons why you are making this choice, with scripture verse(s), parental signature and date.





**VERITAS CHRISTIAN ACADEMY**  
385 Houses Corner Road  
Sparta, NJ 07871

## **STANDING ORDERS**

### **PHYSICIAN'S MEDICATION ORDER FORM**

School Year \_\_\_\_\_

\_\_\_\_\_ (Student's name) may receive the following medications,  
with written parental permission only:

- ( ) Acetaminophen 325 mg tablets. May take 2 tablets every 4 hours as needed for minor aches, pains, headache or a fever  $> 101$ .
- ( ) Ibuprofen 200 mg tablets. May take 2 tablets every 4-6 hours as needed for minor aches, pains, headache or a fever  $> 101$ .
- ( ) Tums 500 mg tablets. May chew 2-4 tablets as needed. May repeat in one hour; may be used for acid indigestion or heartburn.
- ( ) Cough drops. One lozenge every 2 hours as needed for cough or sore throat.
- ( ) Benadryl 25 mg tablets. 1-2 tablets every 4 hours as needed for allergic reaction.

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

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



# UNIVERSAL CHILD HEALTH RECORD

Endorsed by: American Academy of Pediatrics, New Jersey Chapter  
New Jersey Academy of Family Physicians  
New Jersey Department of Health

## SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name (Last)		(First)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Child's Health Insurance Carrier		
Parent/Guardian Name		Home Telephone Number		Work Telephone/Cell Phone Number
Parent/Guardian Name		Home Telephone Number		Work Telephone/Cell Phone Number
<i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>				
Signature/Date			This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	

## SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormalities Noted:	
Weight (must be taken within 30 days for WIC)	
Height (must be taken within 30 days for WIC)	
Head Circumference (if <2 Years)	
Blood Pressure (if ≥3 Years)	

### IMMUNIZATIONS

- ☐ Immunization Record Attached  
☐ Date Next Immunization Due:

### MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments

### PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note If Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.

Name of Health Care Provider (Print)

Health Care Provider Stamp:

Signature/Date



# 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 a copy of 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	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 the 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				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"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease 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?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY				39. Have you ever been unable to move your arms or legs after being hit or falling?			
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)?				40. Have you ever become ill while exercising in the heat?			
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?				41. Do you get frequent muscle cramps when exercising?			
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?				42. Do you or someone in your family have sickle cell trait or disease?			
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?				43. Have you had any problems with your eyes or vision?			
BONE AND JOINT QUESTIONS				44. Have you had any eye injuries?			
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?				45. Do you wear glasses or contact lenses?			
18. Have you ever had any broken or fractured bones or dislocated joints?				46. Do you wear protective eyewear, such as goggles or a face shield?			
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?				47. Do you worry about your weight?			
20. Have you ever had a stress fracture?				48. Are you trying to or has anyone recommended that you gain or lose weight?			
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)				49. Are you on a special diet or do you avoid certain types of foods?			
22. Do you regularly use a brace, orthotics, or other assistive device?				50. Have you ever had an eating disorder?			
23. Do you have a bone, muscle, or joint injury that bothers you?				51. Do you have any concerns that you would like to discuss with a doctor?			
24. Do any of your joints become painful, swollen, feel warm, or look red?				FEMALES ONLY			
25. Do you have any history of juvenile arthritis or connective tissue disease?				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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New Jersey Department of Education 2014; Pursuant to P.L. 2013, c. 71

9-2081/0410





# **PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM**

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

## **PHYSICIAN REMINDERS**

- 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?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP	Pulse	Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL		
APPEARANCE		
<ul style="list-style-type: none"> <li>Marian stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</li> </ul>		
Eyes/ears/nose/throat		
<ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>		
Lymph nodes		
Heart*		
<ul style="list-style-type: none"> <li>Murmurs (auscultation standing, supine, +/- Valsalva)</li> <li>Location of point of maximal impulse (PMI)</li> </ul>		
Pulses		
<ul style="list-style-type: none"> <li>Simultaneous femoral and radial pulses</li> </ul>		
Lungs		
Abdomen		
Genitourinary (males only)*		
Skin		
<ul style="list-style-type: none"> <li>HSV lesions suggestive of MRSA, tinea corporis</li> </ul>		
Neurologic*		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional		
<ul style="list-style-type: none"> <li>Duck-walk, single leg hop</li> </ul>		

\*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

\*Consider GU exam if in private setting. Having third party present is recommended.

\*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, a 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, advanced practice nurse (APN), physician assistant (PA) (print/type) \_\_\_\_\_ Date \_\_\_\_\_

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

Signature of physician, APN, PA \_\_\_\_\_



# **PREPARTICIPATION PHYSICAL EVALUATION THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM**

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

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

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Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

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

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



# ■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name \_\_\_\_\_ Sex ☐ M ☐ F Age \_\_\_\_\_ Date of birth \_\_\_\_\_

☐ 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 \_\_\_\_\_

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

Other information \_\_\_\_\_

### HCP OFFICE STAMP

### SCHOOL PHYSICIAN:

Reviewed on \_\_\_\_\_  
(Date)

Approved \_\_\_\_\_ Not Approved \_\_\_\_\_

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

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, advanced practice nurse (APN), physician assistant (PA) \_\_\_\_\_ Date \_\_\_\_\_

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

Signature of physician, APN, PA \_\_\_\_\_

Completed Cardiac Assessment Professional Development Module

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



# Asthma Treatment Plan – Student Parent Instructions



The PACNJ Asthma Treatment Plan is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

**1. Parents/Guardians:** Before taking this form to your Health Care Provider, complete the top left section with:

- Child's name
- Child's doctor's name & phone number
- Parent/Guardian's name & phone number
- Child's date of birth
- An Emergency Contact person's name & phone number

**2. Your Health Care Provider will complete the following areas:**

- The effective date of this plan
- The medicine information for the Healthy, Caution and Emergency sections
- Your Health Care Provider will check the box next to the medication and check how much and how often to take it
- Your Health Care Provider may check "OTHER" and:
  - ❖ Write in asthma medications not listed on the form
  - ❖ Write in additional medications that will control your asthma
  - ❖ Write in generic medications in place of the name brand on the form
- Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow

**3. Parents/Guardians & Health Care Providers together will discuss and then complete the following areas:**

- Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
- Child's asthma triggers on the right side of the form
- Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

**4. Parents/Guardians:** After completing the form with your Health Care Provider:

- Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
- Keep a copy easily available at home to help manage your child's asthma
- Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

## PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

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

Phone \_\_\_\_\_

Date \_\_\_\_\_

## FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

**RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY**

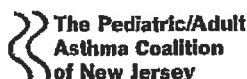
- ☐ I do request that my child be **ALLOWED** to carry the following medication \_\_\_\_\_ for self-administration in school pursuant to N.J.A.C.:6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

- ☐ I **DO NOT** request that my child self-administer his/her asthma medication.

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

Phone \_\_\_\_\_

Date \_\_\_\_\_



"Your Pathway to Asthma Control"  
PACNJ approved Plan available at  
[www.pacnj.org](http://www.pacnj.org)

Disclaimer: The use of this Pediatric/Adult Asthma Treatment Plan and its content is at your own risk. The content is provided on an "as is" basis. The American Lung Association of the Mid-Atlantic (ALAA-M), the Pediatric/Adult Asthma Coalition of New Jersey and all affiliates disclaim all warranties, express or implied, statutory or otherwise, including but not limited to the implied warranties of merchantability, non-infringement of third parties' rights, and fitness for a particular purpose. ALAA-M makes no representations or warranties about the accuracy, reliability, completeness, currency or timeliness of the content. ALAA-M makes no warranty, representation or guarantee that the information will be uninterrupted in content or that any effects can be connected in any event that ALAA-M be liable for any damages (including, without limitation, incidental and consequential damages, personal injury, property damage, loss profits, or damages resulting from data or business interruption) resulting from the use or inability to use the content of this Asthma Treatment Plan whether based on warranty, contract, tort or any other legal theory, and whether or not ALAA-M is advised of the possibility of such damages. ALAA-M and its affiliates are not liable for any claims, whatsoever, caused by your use or misuse of the Asthma Treatment Plan, now or in the future.

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IN NEW JERSEY





# Asthma Treatment Plan – Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)

The Pediatric/Adult  
Asthma Coalition  
of New Jersey  
"Your Pathway to Asthma Control"  
Asthma approved Plan available at  
www.pacnj.org

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AMERICAN  
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IN NEW JERSEY

NJ Health  
New Jersey Department of Health



(Please Print)

Name		Date of Birth	Effective Date
Doctor	Parent/Guardian (if applicable)		Emergency Contact
Phone	Phone		Phone

## HEALTHY (Green Zone) IIII



You have all of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above \_\_\_\_\_

**Take daily control medicine(s). Some inhalers may be more effective with a "spacer" - use if directed.**

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Advair® HFA <input type="checkbox"/> 45, <input type="checkbox"/> 115, <input type="checkbox"/> 230	2 puffs twice a day
<input type="checkbox"/> Aerospan™	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Alvesco® <input type="checkbox"/> 80, <input type="checkbox"/> 160	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Dulera® <input type="checkbox"/> 100, <input type="checkbox"/> 200	2 puffs twice a day
<input type="checkbox"/> Flovent® <input type="checkbox"/> 44, <input type="checkbox"/> 110, <input type="checkbox"/> 220	2 puffs twice a day
<input type="checkbox"/> Qvar® <input type="checkbox"/> 40, <input type="checkbox"/> 80	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Symbicort® <input type="checkbox"/> 80, <input type="checkbox"/> 160	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Advair Diskus® <input type="checkbox"/> 100, <input type="checkbox"/> 250, <input type="checkbox"/> 500	1 inhalation twice a day
<input type="checkbox"/> Asmanex® Twisthaler® <input type="checkbox"/> 110, <input type="checkbox"/> 220	<input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Flovent® Diskus® <input type="checkbox"/> 50 <input type="checkbox"/> 100 <input type="checkbox"/> 250	1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler® <input type="checkbox"/> 90, <input type="checkbox"/> 180	<input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Pulmicort Respules® (Budesonide) <input type="checkbox"/> 0.25, <input type="checkbox"/> 0.5, <input type="checkbox"/> 1.0	1 unit nebulized <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Singulair® (Montelukast) <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 10 mg	1 tablet daily
<input type="checkbox"/> Other	
<input type="checkbox"/> None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take \_\_\_\_\_ puff(s) \_\_\_\_\_ minutes before exercise.

## Triggers

Check all items that trigger patient's asthma:

- ☐ Colds/flu
- ☐ Exercise
- ☐ Allergens
  - ☐ Dust Mites, dust, stuffed animals, carpet
  - ☐ Pollen - trees, grass, weeds
  - ☐ Mold
  - ☐ Pets - animal dander
  - ☐ Pests - rodents, cockroaches
- ☐ Odors (Irritants)
  - ☐ Cigarette smoke & second hand smoke
  - ☐ Perfumes, cleaning products, scented products
  - ☐ Smoke from burning wood, inside or outside
- ☐ Weather
  - ☐ Sudden temperature change
  - ☐ Extreme weather - hot and cold
  - ☐ Ozone alert days
- ☐ Foods:
  - ☐ \_\_\_\_\_
  - ☐ \_\_\_\_\_
  - ☐ \_\_\_\_\_
  - ☐ \_\_\_\_\_
- ☐ Other:
  - ☐ \_\_\_\_\_
  - ☐ \_\_\_\_\_
  - ☐ \_\_\_\_\_
  - ☐ \_\_\_\_\_

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

## CAUTION (Yellow Zone) IIII



You have any of these:

- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other: \_\_\_\_\_

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from \_\_\_\_\_ to \_\_\_\_\_

**Continue daily control medicine(s) and ADD quick-relief medicine(s).**

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
<input type="checkbox"/> Xopenex®	2 puffs every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Duoneb®	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Xopenex® (Levalbuterol) <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Combivent Respimat®	1 Inhalation 4 times a day
<input type="checkbox"/> Increase the dose of, or add:	
<input type="checkbox"/> Other	

**• If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

## EMERGENCY (Red Zone) IIII



Your asthma is getting worse fast:

- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other: \_\_\_\_\_

And/or Peak flow below \_\_\_\_\_

**Take these medicines NOW and CALL 911. Asthma can be a life-threatening illness. Do not wait!**

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
<input type="checkbox"/> Xopenex®	4 puffs every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg	1 unit nebulized every 20 minutes
<input type="checkbox"/> Duoneb®	1 unit nebulized every 20 minutes
<input type="checkbox"/> Xopenex® (Levalbuterol) <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	1 unit nebulized every 20 minutes
<input type="checkbox"/> Combivent Respimat®	1 inhalation 4 times a day
<input type="checkbox"/> Other	

Permission to Self-administer Medication:

- ☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.
- ☐ This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE \_\_\_\_\_

Physician's Orders

DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

PHYSICIAN STAMP

REVISED AUGUST 2014

Permission to reproduce blank forms - www.pacnj.org

Make a copy for parent and for physician file, send original to school nurse or child care provider.



# Food Allergy Action Plan

Student's

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Teacher: \_\_\_\_\_

Place  
Child's  
Picture  
Here

ALLERGY TO: \_\_\_\_\_

Asthmatic Yes\* ☐ No ☐ \*Higher risk for severe reaction

## ◆ STEP 1: TREATMENT ◆

Symptoms:		Give Checked Medication **: ** (To be determined by physician authorizing treatment)	
▪	If a food allergen has been ingested, but <i>no symptoms</i> :	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
▪	Mouth Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
▪	Skin Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
▪	Gut Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
▪	Throat† Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
▪	Lung† Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
▪	Heart† Weak or thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
▪	Other† _____	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine
▪	If reaction is progressing (several of the above areas affected), give:	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

## DOSAGE

**Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

**Antihistamine:** give \_\_\_\_\_  
medication/dose/route

**Other:** give \_\_\_\_\_  
medication/dose/route

**IMPORTANT:** Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

## ◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: \_\_\_\_\_). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. \_\_\_\_\_ Phone Number: \_\_\_\_\_

3. Parent \_\_\_\_\_ Phone Number(s) \_\_\_\_\_

4. Emergency contacts:

Name/Relationship

Phone Number(s)

a. \_\_\_\_\_ 1.) \_\_\_\_\_ 2.) \_\_\_\_\_

b. \_\_\_\_\_ 1.) \_\_\_\_\_ 2.) \_\_\_\_\_

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

(Required)



## Website Resources

- 1 Sudden Death in Athletes  
<http://tinyurl.com/m2gjmrv>
- 2 Hypertrophic Cardiomyopathy Association  
[www.4hcm.org](http://www.4hcm.org)
- 3 American Heart Association [www.heart.org](http://www.heart.org)

## Collaborating Agencies:

American Academy of Pediatrics  
New Jersey Chapter

3636 Quakerbridge Road, Suite 108

Hamilton, NJ 08619

(p) 609-842-0014

(f) 609-842-0015

[www.aapnj.org](http://www.aapnj.org)

American Heart Association

1 Union Street, Suite 301

Robbinsville, NJ 08861

(p) 609-208-0020

[www.heart.org](http://www.heart.org)

New Jersey Department of Education

PO Box 500

Trenton, NJ 08625-0500

(p) 609-292-5935

[www.state.nj.us/education/](http://www.state.nj.us/education/)

New Jersey Department of Health

P.O. Box 360

Trenton, NJ 08625-0360

(p) 609-292-7837

[www.state.nj.us/health](http://www.state.nj.us/health)

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# SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

The Basic Facts on  
Sudden Cardiac Death  
in Young Athletes

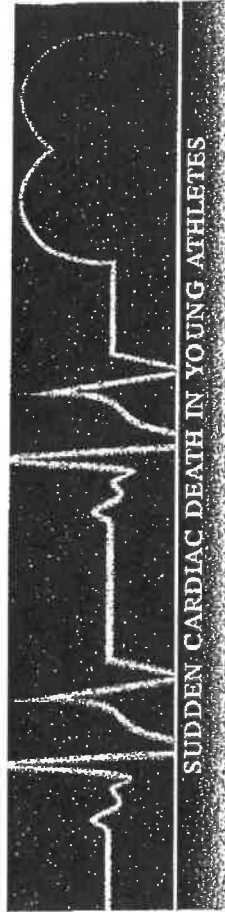


STATE OF NEW JERSEY  
DEPARTMENT OF EDUCATION

American Academy of Pediatrics  
DEDICATED TO THE HEALTH OF ALL CHILDREN®

American Heart  
Association

Learn and Live



**S**udden death in young athletes between the ages of 10 and 19 is very rare. What, if anything, can be done to prevent this kind of tragedy?

**What is sudden cardiac death in the young athlete?**

Sudden cardiac death is the result of an unexpected failure of proper heart function, usually (about 60% of the time) during or immediately after exercise without trauma. Since the heart stops pumping adequately, the athlete quickly collapses, loses consciousness, and ultimately dies unless normal heart rhythm is restored using an automated external defibrillator (AED).

**How common is sudden death in young athletes?**

Sudden cardiac death in young athletes is very rare. About 100 such deaths are reported in the United States per year. The chance of sudden death occurring to any individual high school athlete is about one in 200,000 per year.

Sudden cardiac death is more common in males than in females; in football and basketball than in other sports; and in African-Americans than in other races and ethnic groups.

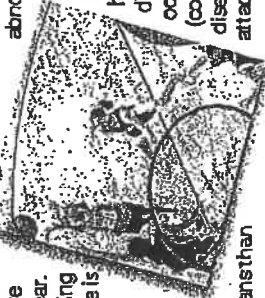


**What are the most common causes?**

Research suggests that the main cause is a loss of proper heart rhythm, causing the heart to quiver instead of pumping blood to the brain and body. This is called ventricular fibrillation (ven-TREE-oh-lar-fib-roo-LAY-shun). The problem is usually caused by one of several cardiovascular abnormalities and electrical diseases of the heart that go unnoticed in healthy-appearing athletes.

The most common cause of sudden death in an athlete is hypertrophic cardiomyopathy (hi-per-TRO-fic CAR-dee-oh-my-OP-a-thee) also called HCM. HCM is a disease of the heart, with abnormal thickening of the heart muscle, which can cause serious heart rhythm problems and blockages to blood flow. This genetic disease runs in families and usually develops gradually over many years.

The second most likely cause is congenital (con-JEN-it-ah) (i.e., present from birth) abnormalities of the coronary arteries. This means that these blood vessels are connected to the main blood vessel of the heart in an abnormal way. This differs from blockages that may occur when people get older (commonly called "coronary artery disease," which may lead to a heart attack).





## SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

What are the current recommendations for screening young athletes?

New Jersey requires all school athletes to be examined by their primary care physician ("medical home") or school physician at least once per year. The New Jersey Department of Education requires use of the specific Preparation Physical Examination Form (PPE). This process begins with the parents and student-athletes answering questions about symptoms during exercise (such as chest pain, lightheadedness, fainting, palpitations or shortness of breath); and questions about family health history.

The primary healthcare provider needs to know if any family member died suddenly during physical activity or during a seizure. They also need to know if anyone in the family under the age of 50 had an unexplained sudden death such as drowning or car accidents. This information must be provided annually for each team because it is so essential to identify those at risk for sudden cardiac death.

The required physical exam includes measurement of blood pressure and a careful listening examination of the heart, especially for murmurs and rhythm abnormalities. If there are no warning signs reported on the health history and no abnormalities discovered on exam, no further evaluation or testing is recommended.

Are there options privately available to screen for cardiac conditions?

Technology-based screening programs, including at least electrocardiogram (ECG) and echocardiogram (ECHO) are available. Parents and patients should consider in addition to the required

ECG, however, these procedures may be expensive and are not currently advised by the American Academy of Pediatrics and the American College of Cardiology unless the PPE reveals an indication for these tests. In addition to the expense, other limitations of technology-based tests include the possibility of "false positives" which leads to unnecessary stress for the student and parent or guardian as well as unnecessary restriction from athletic participation.

The United States Department of Health and Human Services offers risk assessment options under the Surgeon General's Family History Initiative available at <http://www.hhs.gov/familyhistory/index.html>.

When should a student athlete see a heart specialist?

If the primary healthcare provider or school physician has concerns, a referral to a child heart specialist, a pediatric cardiologist, is recommended. This specialist will perform a more thorough evaluation, including an electrocardiogram (ECG), which is a graph of the electrical activity of the heart. An echocardiogram, which is an ultrasound test to allow for direct visualization of the heart structure, will likely also be done. The specialist may also order a treadmill exercise test and a monitor to enable a longer recording of the heart rhythm. None of the testing is invasive or uncomfortable.

Can sudden cardiac death be prevented just through proper screening?

A proper evaluation should find most, but not all, conditions that would cause sudden death in the athlete. This is because some diseases are difficult to uncover and may only develop later in life. Others can develop following a

Myocarditis (my-oh-car-DEE-tis), an acute inflammation of the heart muscle (usually due to a virus).

Dilated cardiomyopathy, an enlargement of the heart for unknown reasons.

Long QT syndrome and other electrical abnormalities of the heart which cause abnormal fast heart rhythms that can also run in families.

Marfan syndrome, an inherited disorder that affects heart valves, walls of major arteries, eyes and the skeleton. It is generally seen in unusually tall athletes, especially if being tall is not common in other family members.

Are there warning signs to watch for?

More than a third of these sudden cardiac deaths, there were warning signs that were not reported or taken seriously. Warning signs are:

- 1 Fainting, a seizure or convulsions during physical activity;
- 1 Fainting or a seizure from emotional excitement, emotional distress or being startled;
- 1 Dizziness or lightheadedness, especially during exertion;
- 1 Chest pains at rest or during exertion;
- 1 Palpitations - awareness of the heart beating unusually (skipping, irregular or extra beats) during athletics or during cool down periods after athletic participation;
- 1 Fatigue or tiring more quickly than peers; or
- 1 Being unable to keep up with friends due to shortness of breath (labored breathing).

normal screening evaluation, such as an infection of the heart muscle from a virus. This is why screening evaluations and a review of the family health history need to be performed on a yearly basis by the athlete's primary healthcare provider. With proper screening and evaluation, most cases can be identified and prevented.

Why have an AED on site during sporting events?

The only effective treatment for ventricular fibrillation is immediate use of an automated external defibrillator (AED). An AED can restore the heart back into a normal rhythm. An AED is also life-saving for ventricular fibrillation caused by a blow to the chest over the heart (commotio cordis).

N.J.S.A. 18A:40-4.1 through c, known as "Janet's Law," requires that at any school-sponsored athletic event or team practice in New Jersey public and nonpublic schools including any of grades K through 12, the following must be available:

- 1 An AED in an unlocked location on school property within a reasonable proximity to the athletic field or gymnasium; and
- 1 A team coach, licensed athletic trainer, or other designated staff member if there is no coach or licensed athletic trainer present, certified in cardiopulmonary resuscitation (CPR) and the use of the AED; or
- 1 A State-certified emergency services provider or other certified first responder.

The American Academy of Pediatrics recommends the AED should be placed in a central location that is accessible and ideally no more than a 1 to 1 1/2 minute walk from any location and that a call is made to activate 911 emergency system while the AED is being retrieved.





**Sudden Cardiac Death Pamphlet**  
**Sign-Off Sheet**

Name of School District: \_\_\_\_\_

Name of Local School: \_\_\_\_\_

I/We acknowledge that we received and reviewed the Sudden Cardiac Death in Young Athletes pamphlet.

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

Parent or Guardian  
Signature: \_\_\_\_\_

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



## **Sports-Related Concussion and Head Injury Fact Sheet and Parent/Guardian Acknowledgement Form**

A concussion is a brain injury that can be caused by a blow to the head or body that disrupts normal functioning of the brain. Concussions are a type of Traumatic Brain Injury (TBI), which can range from mild to severe and can disrupt the way the brain normally functions. Concussions can cause significant and sustained neuropsychological impairment affecting problem solving, planning, memory, attention, concentration, and behavior.

The Centers for Disease Control and Prevention estimates that 300,000 concussions are sustained during sports related activities nationwide, and more than 62,000 concussions are sustained each year in high school contact sports. Second-impact syndrome occurs when a person sustains a second concussion while still experiencing symptoms of a previous concussion. It can lead to severe impairment and even death of the victim.

Legislation (P.L. 2010, Chapter 94) signed on December 7, 2010, mandated measures to be taken in order to ensure the safety of K-12 student-athletes involved in interscholastic sports in New Jersey. It is imperative that athletes, coaches, and parent/guardians are educated about the nature and treatment of sports related concussions and other head injuries. The legislation states that:

- All Coaches, Athletic Trainers, School Nurses, and School/Team Physicians shall complete an Interscholastic Head Injury Safety Training Program by the 2011-2012 school year.
- All school districts, charter, and non-public schools that participate in interscholastic sports will distribute annually this educational fact to all student athletes and obtain a signed acknowledgement from each parent/guardian and student-athlete.
- Each school district, charter, and non-public school shall develop a written policy describing the prevention and treatment of sports-related concussion and other head injuries sustained by interscholastic student-athletes.
- Any student-athlete who participates in an interscholastic sports program and is suspected of sustaining a concussion will be immediately removed from competition or practice. The student-athlete will not be allowed to return to competition or practice until he/she has written clearance from a physician trained in concussion treatment and has completed his/her district's graduated return-to-play protocol.

### **Quick Facts**

- Most concussions do not involve loss of consciousness
- You can sustain a concussion even if you do not hit your head
- A blow elsewhere on the body can transmit an "impulsive" force to the brain and cause a concussion

### **Signs of Concussions (Observed by Coach, Athletic Trainer, Parent/Guardian)**

- Appears dazed or stunned
- Forgets plays or demonstrates short term memory difficulties (e.g. unsure of game, opponent)
- Exhibits difficulties with balance, coordination, concentration, and attention
- Answers questions slowly or inaccurately
- Demonstrates behavior or personality changes
- Is unable to recall events prior to or after the hit or fall

### **Symptoms of Concussion (Reported by Student-Athlete)**

- |                                      |  |
|--------------------------------------|--|
| • Headache                           | • Sensitivity to light/sound   |
| • Nausea/vomiting                    | • Feeling of sluggishness or foginess                                |
| • Balance problems or dizziness      | • Difficulty with concentration, short term memory, and/or confusion |
| • Double vision or changes in vision |  |



**What Should a Student-Athlete do if they think they have a concussion?**

- **Don't hide it.** Tell your Athletic Trainer, Coach, School Nurse, or Parent/Guardian.
- **Report it.** Don't return to competition or practice with symptoms of a concussion or head injury. The sooner you report it, the sooner you may return-to-play.
- **Take time to recover.** If you have a concussion your brain needs time to heal. While your brain is healing you are much more likely to sustain a second concussion. Repeat concussions can cause permanent brain injury.

**What can happen if a student-athlete continues to play with a concussion or returns to play too soon?**

- Continuing to play with the signs and symptoms of a concussion leaves the student-athlete vulnerable to second impact syndrome.
- Second impact syndrome is when a student-athlete sustains a second concussion while still having symptoms from a previous concussion or head injury.
- Second impact syndrome can lead to severe impairment and even death in extreme cases.

**Should there be any temporary academic accommodations made for Student-Athletes who have suffered a concussion?**

- To recover cognitive rest is just as important as physical rest. Reading, texting, testing-even watching movies can slow down a student-athletes recovery.
- Stay home from school with minimal mental and social stimulation until all symptoms have resolved.
- Students may need to take rest breaks, spend fewer hours at school, be given extra time to complete assignments, as well as being offered other instructional strategies and classroom accommodations.

**Student-Athletes who have sustained a concussion should complete a graduated return-to-play before they may resume competition or practice, according to the following protocol:**

- **Step 1:** Completion of a full day of normal cognitive activities (school day, studying for tests, watching practice, interacting with peers) without reemergence of any signs or symptoms. If no return of symptoms, next day advance.
- **Step 2:** Light Aerobic exercise, which includes walking, swimming, and stationary cycling, keeping the intensity below 70% maximum heart rate. No resistance training. The objective of this step is increased heart rate.
- **Step 3:** Sport-specific exercise including skating, and/or running; no head impact activities. The objective of this step is to add movement.
- **Step 4:** Non contact training drills (e.g. passing drills). Student-athlete may initiate resistance training.
- **Step 5:** Following medical clearance (consultation between school health care personnel and student-athlete's physician), participation in normal training activities. The objective of this step is to restore confidence and assess functional skills by coaching and medical staff.
- **Step 6:** Return to play involving normal exertion or game activity.

For further information on Sports-Related Concussions and other Head Injuries, please visit:

[www.cdc.gov/concussion/sports/index.html](http://www.cdc.gov/concussion/sports/index.html)

[www.nfhs.com](http://www.nfhs.com)

[www.ncaa.org/health-safety](http://www.ncaa.org/health-safety)

[www.bianj.org](http://www.bianj.org)

[www.atsni.org](http://www.atsni.org)

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

\_\_\_\_\_  
Print Student-Athlete's Name

\_\_\_\_\_  
Date

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

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

\_\_\_\_\_  
Date

