DIAA ATHLETIC PHYSICAL AND CONSENT FORMS

Upon publication of this packet, these forms MUST be utilized when completing required DIAA forms for athletic participation. Each year, the DIAA will utilize this cover letter to update providers on any important changes and important dates.

The DIAA Sports Medicine Advisory Committee recommends that the required forms be completed by the student athlete’s primary care provider (medical home) to ensure continuity of medical care. These forms must be completed after April 1st each year based on a physical performed by the signing physician within one year of the date of signature.

Important Information:

- Please refer to COVID information from Center for Disease Control and Prevention (CDC) and Delaware Department of Public Health (DPH) for the latest health and safety information.

- On the history form (page 3), all questions should be answered based on complete medical history (not just in the last year).

- The date the forms are filled out does not have to be the same day that the physical was performed. See above for timing of physical.
# Delaware Interscholastic Athletic Association
## Pre-Participation Physical Evaluation/Consent Form

The DIAA pre-participation physical evaluation and consent form consists of seven pages. Pages two, three, and five require a parent's signature, while pages six and seven are references for the parent and student athlete to keep. Page four requires the exam date and physician's signature, and page five requires the clearance to participate date and qualified health care professional’s signature (RN/ATC). The student must be cleared to participate on or after April 1 based on a physical examination conducted within 12 months of the signature. The clearance is valid through June 30 of the following school year unless a re-examination is required.

Name of Athlete: __________________________ School: __________________________
Grade: _____ Age: _____ Gender: _____ Date of Birth: _____ Phone: __________________________
Parent/Guardian Name: (Please Print): __________________________

For the physicals of 9th graders or new school enterers, please check here indicating immunization form attached: □

### PARENT/GUARDIAN/STUDENT CONSENTS

____________________________ has my permission to participate in all interscholastic sports NOT checked below

<table>
<thead>
<tr>
<th>Sport</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseball</td>
<td>(B)</td>
</tr>
<tr>
<td>Basketball (G)(B)</td>
<td>(B)</td>
</tr>
<tr>
<td>Cross Country (G)(B)</td>
<td>(B)</td>
</tr>
<tr>
<td>Field Hockey</td>
<td></td>
</tr>
<tr>
<td>Football</td>
<td></td>
</tr>
<tr>
<td>Golf</td>
<td></td>
</tr>
<tr>
<td>Lacrosse (G)(B)</td>
<td>(B)</td>
</tr>
<tr>
<td>Soccer (G)(B)</td>
<td>(B)</td>
</tr>
<tr>
<td>Softball</td>
<td></td>
</tr>
<tr>
<td>Swimming (G)(B)</td>
<td></td>
</tr>
<tr>
<td>Tennis (G) (B)</td>
<td>(B)</td>
</tr>
<tr>
<td>Track (G) (B)</td>
<td>(B)</td>
</tr>
<tr>
<td>Volleyball</td>
<td></td>
</tr>
<tr>
<td>Wrestling</td>
<td></td>
</tr>
<tr>
<td>Cheerleading</td>
<td></td>
</tr>
<tr>
<td>Unified Football</td>
<td></td>
</tr>
<tr>
<td>Unified Basketball</td>
<td></td>
</tr>
<tr>
<td>Unified Track</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

1. My permission extends to all interscholastic activities whether conducted on or off school premises. I have read and discussed the Parent/Player Concussion Information Document; Sudden Cardiac Arrest Awareness Sheet and I will retain those pages for my reference. I have also discussed with him/her and we understand that physical injury, including paralysis, coma or death and exposure to COVID-19 can occur as a result of participation in interscholastic athletics. I waive any claim for injury, illness, or damage incurred by said participant while participating in the activities NOT checked above.

Parent Signature: __________________________ Date: ________________
Student Signature: __________________________ Date: ________________

2. To enable DIAA and its full and associate member schools to determine whether herein named student is eligible to participate in interscholastic athletics, I hereby consent to the release of any and all portions of school record files, beginning with the sixth grade, of the herein named student, including but not limited to, birth and age records, name and residence of student, health records, academic work completed, grades received and attendance records.

Parent Signature: __________________________ Date: ________________

3. I further consent to DIAA, and its full and associate member schools use of the herein named student's name, likeness, and athletically related information in reports of interscholastic practices, scrimmage or contests, promotional literature of the association, and other materials and releases related to interscholastic athletics.

Parent Signature: __________________________ Date: ________________

4. By this signature, I hereby consent to allow the physician(s) and other health care provider(s) selected by myself or the schools to perform a pre-participation examination on my child and to provide treatment for any injury received while participating in or training for athletics for his/her school. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation, with coaches, medical staff, Delaware Interscholastic Athletic Association, and other school personnel as deemed necessary. Such information may be used for injury surveillance purposes.

Parent Signature: __________________________ Date: ________________

5. By this signature, I agree to notify the physician and school of any health changes during the school year that could impact participation in interscholastic athletics.

Parent Signature: __________________________ Date: ________________

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**HISTORY FORM** *Form completed annually along with a Consent & Medical Card. Athlete and parent should fill out the form prior to visit.*

Name: ___________________________ Age: ___________ Date of Birth: ___________ Grade: ___________

Sex: _______ School: ____________________ Sport(s): ___________________

List past and current medical conditions: ____________________________________________________________________________

Have you ever had surgery? If yes list all past surgical procedures: __________________________________________________________

List all current prescriptions, OTC medicines, and supplements (herbal & nutritional): ____________________________________________________________________________

List all of your allergies (medicines, pollens, food, stinging insects, etc.): ____________________________________________________________________________

<table>
<thead>
<tr>
<th>Feeling nervous, anxious, or on edge</th>
<th>Not at all</th>
<th>Several days</th>
<th>Over half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

*Mental Health: A sum of >= 3 for questions 14, 15, 16, 17, 18, and 21, is considered positive.

GENERAL QUESTIONS

1. Do you have any concerns you would like to discuss with your provider? Yes No

2. Has a provider ever denied or restricted your participation in sports for any reason? Yes No

3. Do you have any medical issues or recent illness? ____________________________

HEART HEALTH QUESTIONS ABOUT YOU:

4. Have you ever passed out or nearly passed out during or after exercise? Yes No

5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? Yes No

6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? Yes No

7. Has a doctor told you that you have any heart issues? Yes No

8. Has a doctor ever requested a test for your heart? For example, electrocardiogram (EKG) or echocardiogram? Yes No

9. Do you get light headed or feel shorter of breath more than your friends during exercise? Yes No

10. Have you ever had a seizure? Yes No

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY:

11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)? Yes No

12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? Yes No

13. Has anyone in your family had a pacemaker, or implanted defibrillator before age 35? Yes No

BONE AND JOINT QUESTIONS

14. Since you were last cleared to play sports, have you had a new injury to a bone, muscle, ligament or tendon? Yes No

MEDICAL QUESTIONS

15. Have you been diagnosed with COVID-19? ________________________________________________________________________

16. Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes No

17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? Yes No

18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area? Yes No

19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methillin-resistant Staphylococcus aureus (MRSA)? Yes No

20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problem? Yes No

21. Have you ever had numbness, tingling, weakness in your arms or legs or been unable to move your arms or legs after being hit or falling? Yes No

22. Have you ever become ill during exercising in the heat? Yes No

23. Do you or someone in your family have sickle cell trait or disease? Yes No

24. Have you ever had or do you have problems with your eyes or vision? Yes No

25. Do you worry much about your weight? Yes No

26. Are you trying or has anyone recommended you gain or lose weight? Yes No

27. Are you on a special diet or do you avoid certain types of foods or food groups? Yes No

28. Have you ever had an eating disorder? Yes No

FEMALES ONLY

29. Have you ever had a menstrual period? Yes No

30. How old were you when you had your first menstrual period? ___________

31. When was your most recent menstrual period? ___________

32. How many periods have you had in the last 12 months? ___________

Answer “Yes” if it ever occurred. Explain “yes” answers here: ____________________________________________

SCHOOL QUALIFIED HEALTHCARE PROFESSIONAL (QHP): (RN/ATC)

If “yes” is answered to any of the above, or “3+” for mental health questions, since the athlete was last cleared for athletic participation, a referral and clearance by the athlete’s primary care provider is required.

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

Signature of Athlete: ___________________________ Date: ___________ Signature Parent/Guardian: ___________________________ Date: ___________

Rev 4/1/2023
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-enhancing 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 (Q4-Q13 of History Form)

<table>
<thead>
<tr>
<th>EXAMINATION</th>
<th>MEDICAL</th>
<th>FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td>Pulse</td>
<td>Vision R 20/</td>
</tr>
<tr>
<td>Weight</td>
<td>6/6</td>
<td>NORMAL</td>
</tr>
<tr>
<td>BP /   /</td>
<td>6/6</td>
<td>NORMAL</td>
</tr>
<tr>
<td>BP /   /</td>
<td>6/6</td>
<td>NORMAL</td>
</tr>
</tbody>
</table>

   - Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse MVP, aortic insufficiency)
   - Eyes/ears/nose/throat
     - Pupils equal
     - Hearing
   - Lymph nodes
   - Heart
     - Murmurs (auscultation standing, supine, +/- Valsalva)
   - Lungs
   - Abdomen
   - Skin
     - Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis
   - Neurological
   - MUSCULOSKELETAL
     - Neck
     - Shoulder and arm
     - Elbow and forearm
     - Wrist, hand, and fingers
     - Hip and thigh
     - Knee
     - Leg and ankle
     - Foot and toes
     - Functional
       - Double-leg squat test, single-leg squat test, and box drop or step drop test

Consider ECG, echocardiogram, echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of these.

HEALTHCARE PROVIDER (MD/DO, NP, PA): THIS FORM [pg4] MUST BE USED IN CONJUNCTION WITH THE MEDICAL HISTORY FORM [pg3]
AND MEDICAL CARD [pg5]. THIS FORM [pg 4] MUST BE SIGNED BY HEALTH CARE PROVIDER (MD/DO, NP, PA).

Comments: ______________________________________________________________

Not Cleared _____ Cleared without restrictions _____ Cleared with the following restrictions: __________________________________________________

Name of Health Care Provider (MD/DO, NP, PA) print or type: ___________________________ Date of Exam: ___________________________
Address: ___________________________________________________________ Phone: ___________________________
Signature of Health Care Provider (MD/DO, NP, PA): ___________________________ Date of Clearance: ___________________________


Rev 4/1/2023
# SCHOOL ATHLETE MEDICAL CARD

(Parent/Guardian: Please complete Sections 1, 2 & 3. Please print.)

## Section 1: Contact / Personal Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Sport(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td>Birthdate:</td>
</tr>
<tr>
<td>School:</td>
<td>Grade:</td>
</tr>
<tr>
<td>Guardian Name:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Phone: (H)</td>
<td>(W)</td>
</tr>
<tr>
<td>(C)</td>
<td>(P)</td>
</tr>
</tbody>
</table>

Other Authorized Person(s) to Contact in Case of Emergency:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Phone(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Phone(s):</td>
</tr>
<tr>
<td>Preference of Physician (And Permission To Contact If Needed):</td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Hospital Preference:</td>
<td>Insurance:</td>
</tr>
<tr>
<td>Policy #:</td>
<td>Group:</td>
</tr>
<tr>
<td></td>
<td>Phone:</td>
</tr>
</tbody>
</table>

## Section 2: Medical Information

Medical Illnesses:  
Last Tetanus (Mo/Yr):  
Allergies:  
Braces/Splints:  
Medications:  

*(Any medication(s) that may need to be taken during competition require a physician’s note.)*

Previous Head/Neck/Back Injury:  
Heat Disorder, Or Sickle Cell Trait:  
Previous Significant Injuries:  
Any Other Important Medical Information:

## Section 3: Consent for Athletic Conditioning, Training, and Health Care Procedures

I hereby give consent for my child to participate in the school’s athletic conditioning and training program and to receive any necessary healthcare treatment, including first aid, diagnostic procedures, and medical treatment, that may be provided by the treating physicians, nurses, athletic trainers, or other healthcare providers employed directly or through a contract by the school, or the opposing team’s school. The healthcare providers have my permission to release my child’s medical information to other healthcare practitioners and school officials. In the event I cannot be reached in an emergency, I give permission for my child to be transported to receive necessary treatment. I understand that Delaware Interscholastic Athletic Association or its associates may request information regarding the athlete’s health status, and I hereby give my permission for the release of this information as long as the information does not personally identify my child.

**Parent/Guardian Signature:**  
**Date:**  
**Athlete’s Signature:**  
**Date:**

## Section 4: Verification of Clearance for Participation

Comments:

**Qualified Health Care Professional’s (QHP) Signature after reviewing PPE:**  
**Date:**

*For School Office Use Only: This card is valid from April 1, 2023 through June 30, 2023.*

Note: If any changes occur, a new card should be completed by the parent/guardian. The original card should be kept on file in the school nurse, athletic director’s or athletic trainer’s office. A copy should be kept in the sports’ athletic kit. This card contains personal medical information and should be treated as confidential by the school, its employees, agents, and contractors.

**Name of School:**  
**Name of School QHP:**
Delaware Interscholastic Athletic Association
Parent/Player Concussion Information Document

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

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

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Signs observed by teammates, parents and coaches may include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headaches</td>
<td>Appears dazed</td>
</tr>
<tr>
<td>Pressure in head</td>
<td>Vacant facial expression</td>
</tr>
<tr>
<td>Neck pain</td>
<td>Confused about assignment</td>
</tr>
<tr>
<td>Balance problems</td>
<td>Forgets plays</td>
</tr>
<tr>
<td>Disturbed vision</td>
<td>Unsure of game/score etc.</td>
</tr>
<tr>
<td>Light/noise sensitivity</td>
<td>Clumsy</td>
</tr>
<tr>
<td>Feeling foggy</td>
<td>Responds slowly</td>
</tr>
<tr>
<td>Drowsiness</td>
<td>Personality changes</td>
</tr>
<tr>
<td>Amnesia</td>
<td>Seizures</td>
</tr>
<tr>
<td>&quot;Don't feel right“</td>
<td>Behavior changes</td>
</tr>
<tr>
<td>Nervousness</td>
<td>Loss of consciousness</td>
</tr>
<tr>
<td>Irritability</td>
<td>Uncoordinated</td>
</tr>
<tr>
<td>Confusion</td>
<td>Can’t recall events before or after hit</td>
</tr>
<tr>
<td>Repeating questions</td>
<td>Concentration problems</td>
</tr>
</tbody>
</table>

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

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

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

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. You should also inform your child’s coach if you think that your child may have a concussion. Remember, it is better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information from the CDC on concussions, you can go to:

http://www.cdc.gov/headsup/youthsports/index.html

For a current update of DIAA policies and procedures on concussions, you can go to:

https://education.delaware.gov/diaa/health_and_safety/concussions_and_sudden_cardiac_arrest/

For a free online training video on concussions, you can go to:

https://nfhslearn.com/courses?searchText=Concussion

All parents and players must sign the signature portion of the PPE indicating they have read and understand the above.

Adapted from the KHSAA, CDC and 3rd International Conference on Concussion in Sport, 4/2011
SUDDEN CARDIAC ARREST AWARENESS SHEET

What is Sudden Cardiac Arrest?
➢ An electrical malfunction (short-circuit) causes the bottom chambers of the heart (ventricles) to beat dangerously fast (ventricular tachycardia or fibrillation) and disrupts the pumping ability of the heart.
➢ Occurs suddenly and often without warning.
➢ The heart cannot pump blood to the brain, lungs and other organs of the body.
➢ The person loses consciousness (passes out) and has no pulse.
➢ Death occurs within minutes if not treated.

What causes Sudden Cardiac Arrest?
➢ Conditions present at birth (inherited and non-inherited heart abnormalities)
➢ A blow to the chest (Commotio Cordis)
➢ An infection/inflammation of the heart, usually caused by a virus. (Myocarditis)
➢ Recreational/Performance-Enhancing drug use.
➢ Other cardiac & medical conditions/Unknown causes. (Obesity/Idiopathic)

What are the symptoms/warning signs of Sudden Cardiac Arrest?
➢ Fainting/blackouts (especially during exercise)
➢ Dizziness
➢ Unusual fatigue/weakness
➢ Chest pain
➢ Shortness of breath
➢ Nausea/vomiting
➢ Palpitations (heart is beating unusually fast or skipping beats)
➢ Family history of sudden cardiac arrest at age < 50

ANY of these symptoms/warning signs may necessitate further evaluation from your physician before returning to practice or a game.

What are ways to screen for Sudden Cardiac Arrest?
➢ The American Heart Association recommends a pre-participation history and physical including 12 important cardiac elements.
➢ The DIAA Pre-Participation Physical Evaluation – Medical History form includes ALL 12 of these important cardiac elements and is mandatory annually. Please answer the heart history questions on the student health history section of the DIAA PPE carefully.
➢ Additional screening using an electrocardiogram and/or an echocardiogram is readily available to all athletes, but is not mandatory.

Where can one find additional information?
➢ Contact your primary care physician
➢ American Heart Association (www.heart.org)
➢ August Heart (www.augustheart.org)
➢ Championship Hearts Foundation (www.champhearts.org)
➢ Cody Stephens Foundation (www.codystephensfoundation.org/)
➢ Parent Heart Watch (www.parentheartwatch.com)
➢ NFHS Learn Center – Sudden Cardiac Arrest Video (www.nfhslearn.com)

All parents and players must sign the signature portion of the PPE indicating they have read and understand the above.