

Omaha Public Schools Sports Medicine Advisory Committee Parent and Student Athlete Concussion Information and Fact Sheet



Concussions may result from sudden trauma, such as sports injuries, that cause the brain to hit the inside of the skull.

In the fall of 2008, the Certified Athletic Trainers and Physicians working with OPS began utilizing new guidelines to evaluate, assess, and manage concussions incurred by OPS student athletes. Since then the guidelines have been reviewed and updated annually to reflect emerging best practices in the recognition and management of concussions in youth sports.

Did You Know?

According to the Center for Disease Control and other publications:

- Each year 300,000 athletes suffer sports-related concussions.
- The national estimate for concussions in high school athletes is 136,000.
- In ages 15-24, sports are the 2nd leading cause of traumatic brain injury.
- Most studies done on concussions focus on the "mature" brain and thus, we cannot ignore the fact that the young brain is still developing and the effects of concussions are not fully understood.
- High school athletes who sustain a concussion demonstrate prolonged memory dysfunction compared with college athletes.
- A concussion is: "getting your bell rung," and "getting dinged."
- Failure to recognize and properly manage a concussion can lead to a catastrophic injury known as "second impact syndrome."
- Second impact syndrome can be catastrophic, even fatal.
- Second impact syndrome is preventable - if concussions are recognized and properly managed:
- April 18, 2011, LB 260 - "The Concussion Awareness Act" was signed into law with the intent to protect the youth participating in athletics across the state from the dangers of concussions that are often unrecognized, undiagnosed, and/or mismanaged.

According to a study by McCrea published in 2004, **The top reasons for athletes not reporting concussions were:**

1. Didn't think the concussion was serious.
2. Didn't want to leave the game.
3. Didn't realize a concussion was sustained.
4. Didn't want to let down their teammates.

Sources:

1 Center for Disease Control, "Heads Up: Concussion in High School Sports." www.cdc.gov

2 Gessel, LM et al. Concussions Among US High School and College Athletes. *Journal of Athletic Training.* 2007; 43(4): 495-203

3 Guskiewicz, KM et al. NATA Position Statement: Management of Sports Related Concussions. *Journal of Athletic Training.* 2004; 39(3) 280-297

WHAT DOES A CONCUSSION LOOK LIKE?

SIGNS:

1. Appears dazed or stunned
2. Is confused about an assignment
3. Forgets plays
4. Moves clumsily or displays problems with balance and coordination
5. Loses consciousness (even briefly)
6. Shows behavioral or personality changes

SYMPTOMS:

1. Headache or "pressure" in the head
2. Nausea
3. Balance problems or dizziness
4. Double or fuzzy vision
5. Sensitivity to light or noise
6. Feeling slowed down, foggy, or groggy
7. Does not "feel right"

Guidelines For Concussion Management:

The Goals and Outcomes of the OPS Sports Medicine Advisory Committee on Concussion Management

| GOAL | GOAL |
|--|--|
| To prevent increasing the severity of the injury. | To prevent re-injury through proper management. |
| Guideline All concussions will be assessed using guidelines established by the 2008 International Conference on Concussion in Sport. <i>For complete details, please see your school's Certified Athletic Trainer.</i> <i>BRAIN INJURIES (CONCUSSIONS) SHOULD NOT BE TAKEN LIGHTLY. ONLY THOUGH IMMEDIATE AND EARLY RECOGNITION AND PROPER MANAGEMENT, CAN WE PREVENT A POTENTIALLY LIFE ALTERING EVENT.</i> | Guideline 1. A student athlete will be removed from a practice or game when he or she is reasonably suspected of sustaining a concussion or head injury; 2. The student athlete will be evaluated by qualified medical personnel; 3. The student athlete will not be allowed to return to play until he or she is asymptomatic and exhibit no neuropsychological or neurocognitive deficits during follow-up ImPact Testing; and 4. The student athlete will not be allowed to return to practice or competition until he or she has been cleared by a physician or OPS Certified Athletic Trainer and has completed a medically supervised stepwise return to play progression. <i>For complete details, please see your school's Certified Athletic Trainer.</i> |

If your son or daughter has sustained a concussion:

1. Seek medical attention (physician, ER, athletic trainer)
2. Keep them out of play
3. Tell all athletic trainers and coaches about any previous or current concussions

Source: Center for Disease Control (www.cdc.gov)

Resources for information on concussions and this policy may be found:

1. Center for Disease Control
www.cdc.gov
2. Omaha Public Schools website
www.ops.org
3. National Athletic Trainers Association
www.nata.org
4. National Federation of State High Schools Association
www.nfhs.org

~ What to Do if You Suspect Your Child Has Suffered a Concussion ~

A student athlete should be taken to the emergency (ER) department if any of the following signs or symptoms are present.

- Headaches that worsen
- Seizures
- Looks very drowsy and cannot be awakened
- Repeated vomiting
- Slurred speech
- Cannot recognize people or places
- Increasing confusion or irritability
- Weakness or numbness in arms or legs
- Neck pain
- Unusual behavior change
- Any loss of consciousness
- Any symptoms that worsen or do not improve overtime
- Increase in the number of symptoms
- Symptoms which begin to interfere with the student's daily activities

OMAHA PUBLIC SCHOOLS HEAD INJURY/CONCUSSION ACKNOWLEDGEMENT FORM

I understand there is a possibility that participation in any sport may result in a head injury and/or concussion. Furthermore, I have been provided with the **Omaha Public Schools Sports Medicine Advisory Committee Parent and Student/Athlete Concussion Information and Fact Sheet** and understand the importance of reporting a head injury and/or concussion to parents, coaches and athletic training staff.

After reading the **Omaha Public Schools Sports Medicine Advisory Committee Parent and Student/Athlete Concussion Information and Fact Sheet**, I am aware of the following information:

- A concussion is a brain injury, which I am responsible for reporting;
- A concussion can affect one's ability to perform everyday activities, affect reaction time, balance, sleep quality, and classroom performance;
- A student athlete will not be allowed to return to a game or practice until cleared by a physician or the OPS Athletic Training Staff;
- Following a concussion, the brain needs time to heal. There is an increased likelihood for a repeat concussion if the individual returns to play before symptoms have resolved;
- In certain instances, repeat concussion can cause permanent brain damage, even death; and
- At any point following a suspected concussion, any of the following individuals reserves the right to voice concern for the safety of a student athlete and prohibit them from returning to play: **physician, coach, student athlete, athletic trainer, parent.**

By signing below, I understand the importance of the statements above and have asked any, and all questions regarding the above statements. I further understand that I will not be allowed to participate in OPS athletics until this form is signed by a parent/guardian.

I hereby attest that I have read, fully understand, and will abide by the above statements.

Student Athlete Name _____

Sport(s) _____

Student Athlete Signature _____

Date _____

Parent/Guardian Signature (required) _____

Date _____

OMAHA PUBLIC SCHOOL BASED HEATH CENTERS FOR SCHOOL AND SPORTS PHYSICALS

Enrollment forms for OPS School Based Health Centers are sent to homes yearly in SIP (Student Information Packet) mailings before the start of the school year.

The following school-based health centers can schedule appointments for sports physicals during regular school hours. These school-based health centers are operated and staffed by the community's federally qualified health centers, each serving 4 schools.

Staffed by Charles Drew Community Health Center, 402-457-1200

(Please call individual school for appointment)

- Belvedere Elementary, 3775 Curtis Ave. (402) 932-1232
- King Science Magnet Middle, 3720 Florence Blvd. (402) 502-5644
- Kellom Elementary, 1311 N. 24th Street (402) 505-5451
- Northwest High Magnet School, 8204 Crown Point Avenue (402) 916-5964

Staffed by OneWorld Community Health Centers, 402-734-4110

- Bryan High School, 4700 Giles Road (402) 991-3904
- Indian Hill Elementary, 3121 U Street (402) 933-4968
- Liberty Elementary, 2021 St. Mary's Ave. (402) 505-8180
- Spring Lake Magnet Elementary, 4215 S. 20th Street (402) 932-7014

Payment options accepted: Medicaid, Kids Connection, private health insurance, or if not yet covered by health insurance, health center staff will work with you to help enroll your children with Kids Connection or Medicaid. Contact one of the health centers if you need more information regarding payment for services. Detailed information is available at www.buildinghealthyfutures.org/sbhc

OMAHA PUBLIC SCHOOLS-Student Form

ATHLETIC INSURANCE COVERAGE

Your school, acting for members of the athletic squad, makes available an Athletic Injury Benefit Plan approved by the Omaha board of Education. The total premium is paid by the student or parent. The purpose of such coverage is to assist in the cost of treatment of accidental injury. Payments are in addition to any payments by another company for the same injury.

SQUAD MEMBERS MUST HAVE INSURANCE COVERAGE TO PARTICIPATE.

Check the statements that apply:

I shall participate in the Athletic Benefit Injury Plan. Enroll online at www.studentinsuranc-kk.com. Click the "Enroll Now" button. See flyer for more information.

I have accident injury coverage with the _____ **Insurance Company.**

Policy No. _____ **Signature of Parent/Guardian** _____

Date ____/____/____ Home Address _____

Note: This form is to be filled out completely and filed in the office of the school before athlete is allowed to practice and/or compete

To be completed for students participating in any NSAA activities.

Student and Parent Consent Form



School Year: 20____-20____

Member School: _____

Name of Student: _____

Date of Birth: _____

Place of Birth: _____

The undersigned(s) are the Student and the parent(s), guardian(s), or person(s) in charge of the above-named Student and are collectively referred to as "Parent".

The Parent and Student hereby:

- (1) Understand and agree that participation in NSAA sponsored activities is voluntary on the part of the Student and is a privilege;
- (2) Understand and agree that (a) by this Consent Form the NSAA has provided notice to the Parent and Student of the existence of potential dangers associated with athletic participation; (b) participation in any athletic activity may involve injury or illness of some type; (c) the severity of such injury can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries to the body's bones, joints, ligaments, tendons, or muscles, to catastrophic injuries to the head, neck and spinal cord, and on rare occasions, injuries so severe as to result in total disability, paralysis and death; (d) the severity of an illness, including contagious diseases such as the COVID 19 virus, and bacterial infections may be so severe as to result in disability and death; and, (e) even the best coaching, the use of the best protective equipment and strict observance of rules, injuries are still a possibility;
- (3) Consent and agree to participation of the Student in NSAA activities subject to all NSAA by-laws and rules interpretations for participation in NSAA sponsored activities, and the activities rules of the NSAA member school for which the Student is participating; and,
- (4) Consent and agree to (a) the disclosure by the Member School at which the Student is enrolled to the NSAA, and subsequent disclosure by the NSAA, of information regarding the Student, including the student's name, address, telephone listing, electronic mail address, photograph, date of and place of birth, major fields of study, dates of attendance, grade level, enrollment status (e.g., full-time or part-time), participation in officially recognized activities and sports, weight and height of as a member of athletic teams, degrees, honors and awards received, statistics regarding performance, records or documentation related to eligibility for NSAA sponsored activities, medical records, and any other information related to the Student's participation in NSAA sponsored activities; and, (b) the Student being photographed, video recorded, audio taped, or recorded by any other means while participating in NSAA activities and contests, consent to and waive any privacy rights with regard to the display of such recordings, and waive any claims of ownership or other rights with regard to such photographs or recordings or to the broadcast, sale or display of such photographs or recordings.
- (5) Consent and agree to authorize licensed sports injury personnel to evaluate and treat any injury or illness that occurs during the student's participation in NSAA activities. This includes all reasonable and necessary preventive care, treatment and rehabilitation for these injuries. This would also include transportation of the student to a medical facility if necessary. Such licensed sports injury personnel are independent providers and are not employed by the NSAA.
- (6) Acknowledge that Parents are obligated to pay for professional medical and/or related services; the NSAA shall not be liable for payment of such services. We give permission to any and all of the Student's health care providers and the NSAA and its employees, staff, agents, and consultants to release and discuss all records and information about the Student including otherwise confidential medical information and records. We understand that this release has been requested and may be used for the purpose of determining eligibility pertaining to activities participation, fitness, injury, injury status, or emergency.

I acknowledge that I have read paragraphs (1) through (6) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities.

Name of Student [Print Name] _____

Student Signature _____

Date _____

(I am)(We are) the Student's [circle appropriate choice] (Parent) (Guardian). (I)(We) acknowledge that (I)(We) have read paragraphs (1) through (6) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities. Having read the warning in paragraph (2) above and understanding the potential risk of injury to my Student, (I)(we) hereby give (my)(our) permission for _____ [insert student name] to practice and compete for the above named high school in activities approved by the NSAA, except those crossed out below:

| | | | | | | |
|---------------|-----------------|-----------------------|------------|-----------|-----------|------------|
| Baseball | Basketball | Cross Country | Debate | Football | Golf | Journalism |
| Music | Play Production | Soccer | Softball | Speech | Swim/Dive | Tennis |
| Track & Field | Unified Bowling | Unified Track & Field | Volleyball | Wrestling | | |

| | | |
|---|---------------------------------|-------------------------|
| Parent(s)/Guardian Printed Name(s)* _____ | Parent/Guardian Signature _____ | Date of Signature _____ |
| | | |

*Both Mother and Father must sign, unless parents are divorced, the custodial parent must sign, or if the student is not living with parents, the student's legal guardian.

OMAHA SOUTH EMERGENCY INFORMATION REPORT 2021-2022

Name _____ **Date of Birth** _____

Address _____ **Male** _____ **Female** _____

Phone _____ **Student ID #** _____ **Grade** _____

Circle sports that athlete intends to compete in:

| | FALL | | | | WINTER | | | SPRING | | | | FALL/WINTER | |
|--------------|------|----|-----|----|--------|----|----|--------|-----|-----|----|-------------|-------|
| GIRLS | CC | Go | SB | VB | BkB | SW | | Soc | Ten | TR | | Dance | Cheer |
| BOYS | CC | FB | Ten | | BkB | SW | WR | BaB | Go | Soc | TR | | Cheer |

Emergency Contact Numbers: (First attempt will always be to home phone number listed above)

Father/Guardian Name _____

Employer _____ **Phone** _____

Mother/Guardian Name _____

Employer _____ **Phone** _____

Name of person other than the above to contact in case of an emergency

Name _____ **Relation** _____ **Phone** _____

Medical Information:

Family Physician _____ **Phone** _____

Health Insurance Company _____ **Policy #** _____

Name of Policy Holder _____

Current Health Information:

Do you regularly take any medications? Yes _____ No _____

If yes, which ones? _____

Required eye-wear? None _____ Glasses _____ Contacts _____

List any allergies or special conditions _____

Record of illnesses that have required doctor's care in the past two years:

Record of any serious injuries or operations:

The team physician, trainer and/or coach will apply first aid treatment until the family doctor or parents can be contacted. We give our consent for coaches, trainers and team physicians to use their own judgement in securing medical aid and ambulance service in case the parents cannot be reached. We further give the above listed the consent to disclose medical information only to those that need such information to perform their jobs adequately.

Parent Signature _____ **Date** _____

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____
 Date of examination: _____ Sport(s): _____
 Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). _____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). _____

Patient Health Questionnaire Version 4 (PHQ-4)
 Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

| | Not at all | Several days | Over half the days | Nearly every day |
|---|------------|--------------|--------------------|------------------|
| Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |

(A sum of ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

| GENERAL QUESTIONS | | |
|---|-----|----|
| (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.) | | |
| | Yes | No |
| 1. Do you have any concerns that you would like to discuss with your provider? | | |
| 2. Has a provider ever denied or restricted your participation in sports for any reason? | | |
| 3. Do you have any ongoing medical issues or recent illness? | | |
| HEART HEALTH QUESTIONS ABOUT YOU | | |
| | Yes | No |
| 4. Have you ever passed out or nearly passed out during or after exercise? | | |
| 5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| 6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? | | |
| 7. Has a doctor ever told you that you have any heart problems? | | |
| 8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. | | |

| HEART HEALTH QUESTIONS ABOUT YOU | | |
|---|-----|----|
| (CONTINUED) | | |
| | Yes | No |
| 9. Do you get light-headed or feel shorter of breath than your friends during exercise? | | |
| 10. Have you ever had a seizure? | | |
| HEART HEALTH QUESTIONS ABOUT YOUR FAMILY | | |
| | Yes | No |
| 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)? | | |
| 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)? | | |
| 13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? | | |

| BONE AND JOINT QUESTIONS | Yes | No |
|---|-----|----|
| 14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? | | |
| 15. Do you have a bone, muscle, ligament, or joint injury that bothers you? | | |
| MEDICAL QUESTIONS | Yes | No |
| 16. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| 18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area? | | |
| 19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)? | | |
| 20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? | | |
| 21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? | | |
| 22. Have you ever become ill while exercising in the heat? | | |
| 23. Do you or does someone in your family have sickle cell trait or disease? | | |
| 24. Have you ever had or do you have any problems with your eyes or vision? | | |

| MEDICAL QUESTIONS (CONTINUED) | Yes | No |
|--|-----|----|
| 25. Do you worry about your weight? | | |
| 26. Are you trying to or has anyone recommended that you gain or lose weight? | | |
| 27. Are you on a special diet or do you avoid certain types of foods or food groups? | | |
| 28. Have you ever had an eating disorder? | | |
| FEMALES ONLY | Yes | No |
| 29. Have you ever had a menstrual period? | | |
| 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 past 12 months? | | |

Explain "Yes" answers here.

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

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, e-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?
- Consider reviewing questions on cardiovascular symptoms (Q4-Q13 of History Form).

| EXAMINATION | | |
|---|---------|--|
| Height: | Weight: | |
| BP: / (/) | Pulse: | Vision: R 20/ L 20/ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N |
| MEDICAL | NORMAL | ABNORMAL FINDINGS |
| Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) | | |
| <ul style="list-style-type: none"> Eyes, ears, nose and throat Pupils equal Hearing | | |
| Lymph nodes | | |
| Heart* <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) | | |
| Lungs | | |
| Abdomen | | |
| Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis | | |
| Neurological | | |
| MUSCULOSKELETAL | NORMAL | ABNORMAL FINDINGS |
| Neck | | |
| Back | | |
| Shoulder and arm | | |
| Elbow and forearm | | |
| Wrist, hand, and fingers | | |
| Hip and thigh | | |
| Knee | | |
| Leg and ankle | | |
| Foot and toes | | |
| Functional <ul style="list-style-type: none"> Double-leg squat test, single-leg squat test, and box drop or step drop test | | |

* Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

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I hereby give permission for the release of the attached student medical history and the results of the actual physical examination to the school for the purposes of participation in athletics and activities.

Parent or Legal Guardian Signature _____

Date _____

PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

- Medically eligible for all sports without restriction
- Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

- Medically eligible for certain sports

- Not medically eligible pending further evaluation
- Not medically eligible for any sports

Recommendations: _____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

Medications: _____

Other information: _____

Emergency contacts: _____

