Buckeye Local High School
Athletic Dept.

10692 State Highway 150, Panther Drive,
Rayland, Ohio 43943
Telephone: 740- 859-2196 X 1131

All Athletes must have a current physical on file in the athletic office before participation in any practice, conditioning, open gym, etc. Physicals are good for 1 calendar year.

All Athletes and any band or club member (all extracurricular activities) must have been drug screened negative before participation. Drug Screens are good for 1 school year.

Attached are the:

- 2020-2021 Physical Packets
  - Physicals tentatively scheduled for the evening of July 8
    - At Wheeling Hospital Tower 4, Room 401
    - Look for updates on the school App as we get closer
    - Athletes need to take a signed copy of their physical with them (attached)
    - Physicals cost $10
    - You can go to your physician if you choose

- 2020-2021 Drug Test Consent From
  - **All testing must be done at Corporate Health in Wheeling Hospital**
  - It is Free
  - Mr. Celestin is once again in charge of drug testing
    - He can be reached at 740-769-7395 X 1705
    - Look for updates on the school App as to testing at our school
  - You can go to their office to get tested if you choose
    - You will need to take a signed consent form (attached)

- Ohio Dept. of Health Concussion info
- Sudden Cardiac Arrest info
- OHSAA info on sportsmanship and eligibility

Tear this front page off. Its for you to keep

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Telephone: 740- 859-2196 X 1131

Buckeye Local Athletics Parent/Coach Communication

Sportsmanship means fair treatment for all – including opponents and officials. Sportsmanship means cheering for the Panthers and not against our opponents or the officials. We are all role models for our athletes, and we want them to see and copy only the best attitudes toward athletics. Buckeye Local has always held high standards and we need your support in keeping them.

The Parent/Coach Relationship We are very pleased that your son/daughter has chosen to participate in the Buckeye Local Athletic Program. We will do all we can to make it a positive experience. Possibly the most important ingredient to achieve this outcome is to ensure that lines of communication are developed and allow for free and easy resolution of questions before they become conflicts. As a parent, you have a right to know what expectations are placed on our student-athletes. This brochure is intended to spell out all levels of communication so that parents, coaches and athletes are aware of the steps they have available to resolve anything they think is, or might become, an issue.

Communication You Should Expect From Your Child's Coach

1. Philosophy of the coach.
2. Expectations the coach has for your child.
3. Locations and times of all practices and contests.
4. Procedure to follow should your child become injured during participation.
5. Participants conduct code and discipline that result in the denial of your child's participation.
6. Disposition of lost/outstanding equipment at the end of the season.

Chain of Command If you elect to pursue any concern you may have regarding a particular program or the entire Buckeye Local Athletic Program, we ask that you follow the channels of communication listed below.

1. Coach
2. Athletic Director
3. Principal
4. Superintendent
5. Board of Education

The Next Step What can a parent do if the meeting with the coach does not provide a satisfactory resolution? Call and set up an appointment with the Athletic Director to discuss the situation. From this meeting, the appropriate next step will be determined.

Communication Coaches Expect From Parents

1. Concerns expressed directly to the coach FIRST.
2. Notification of any scheduled conflicts well in advance.
3. Specific concern in regard to a coach's philosophy and/or expectations.

As your child becomes involved in various programs at the Buckeye Local Schools, he/she will experience some of the most rewarding moments of their lives. It is important to understand that there also may be times when things do not go the way you or your child wishes. At these times, discussion with the coach (or teacher for that matter) may be desirable to clear up the issue and avoid any misunderstanding.

Appropriate Concerns to Discuss With Coaches

1. The treatment of your child, mentally and physically.
2. Ways to help your child improve. 3.Concerns about your child's behavior.

It is very difficult to accept the fact that your child is not playing as much as you would want. Coaches are professionals. They make judgment decisions based on what they believe to be best for all students involved. As you have seen from the list above, certain things can be and should be discussed with your child's coach. Other things, such as those on the following page, must be left to the discretion of the coach.

Issues NOT Appropriate to Discuss With Coaches

1. Playing time.
2. Team strategy.
3. Play calling.
4. Matters concerning other student-athletes.

Do You Have a Concern to Discuss With a Coach? There are situations that may require a conference between the coach and the parent. These are to be encouraged. It is important that both parties involved have a clear understanding of the person's position. When these conferences are necessary, the following procedure should be followed to help promote a resolution to the issue of concern.

1. Call the coach to set up an appointment.
2. If the coach cannot be reached after a reasonable time, call the Athletic Director. 740-859-2196 X 1131 He or she will arrange the appointment for you.
3. Please do not attempt to confront a coach before or after a contest or practice. These can be emotional times for both the parent and coach. Meetings of this nature do not promote resolution and may even complicate the issue.

Important Web Sites and other Info:

WWW.OVAC.ORG	WWW.OHSAA.ORG
Directions	Eligibility
www.BMconference.org	WWW.BUCKEYELOCAL.NET
Jr. High	Forms
https://arbiterlive.com/	**School Apps: Search Buckeye Local HS and or JH**
Schedules	***Follow Buckeye Local HS on Facebook or Twitter***

PREPARTICIPATION PHYSICAL EVALUATION – Ohio High School Athletic Association - 2020 -2021

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 (i.e., 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.

Additional Questions as authorized by the Ohio High School Athletic Association – These questions were not a part of the revised 5th edition PPE as authored by the American Academy of Pediatrics.

1. On average, how many days per week do you engage in moderate to strenuous exercise (makes you breathe heavily or sweat)? _____
2. On average, how many minutes per week do you engage in exercise at this level? _____

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 – Ohio High School Athletic Association – 2020-2021

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name:_____ Date of birth: _____

1. Type of disability:
2. Date of disability:
3. Classification (if available):
4. Cause of disability (birth, disease, injury, or other):
5. List the sports you are playing:

	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or 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 as having 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.

_____

_____

_____

Please indicate whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (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.

_____

_____

_____

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 – Ohio High School Athletic Association – 2020-2021

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

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: □ Y □ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • 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 • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a]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, DC, NP, or PA

PREPARTICIPATION PHYSICAL EVALUATION – OHIO HIGH SCHOOL ATHLETIC ASSOCIATION – 2020-21

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 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 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, DC, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

This Page must be filled out by All Athletes and their parents!

PREPARTICIPATION PHYSICAL EVALUATION 2020-2021 OHSAA FORM 1 of 4

THE STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE SCHOOL

OHSAA AUTHORIZATION FORM 2020-2021

I hereby authorize the release and disclosure of the personal health information of _____ ("Student"), as described below, to **Buckeye Local Jr./ Sr. High School**.

The information described below may be released to the School principal or assistant principal, athletic director, coach, athletic trainer, physical education teacher, school nurse or other member of the School's administrative staff as necessary to evaluate the Student's eligibility to participate in school sponsored activities, including but not limited to interscholastic sports programs, physical education classes or other classroom activities.

Personal health information of the Student which may be released and disclosed includes records of physical examinations performed to determine the Student's eligibility to participate in school sponsored activities, including but not limited to the Pre-participation Evaluation form or other similar document required by the School prior to determining eligibility of the Student to participate in classroom or other School sponsored activities; records of the evaluation, diagnosis and treatment of injuries which the Student incurred while engaging in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in school sponsored activities.

The personal health information described above may be released or disclosed to the School by the Student's personal physician or physicians; a physician or other health care professional retained by the School to perform physical examinations to determine the Student's eligibility to participate in certain school sponsored activities or to provide treatment to students injured while participating in such activities, whether or not such physicians or other health care professionals are paid for their services or volunteer their time to the School; or any other EMT, hospital, physician or other health care professional who evaluates, diagnoses or treats an injury or other condition incurred by the student while participating in school sponsored activities.

I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored and classroom activities, and that the School is a not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the School is covered under the federal regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.

I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student's participation in certain school sponsored activities may be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to the school principal (or designee) whose name and address appears below.

Name of Principal: Lucas Parsons-Jason Kovalski Buckeye Local Jr./Sr. High School

School Address: **10692 State Highway 150, Rayland Ohio 43943**

This authorization will expire when the student is no longer enrolled as a student at the school.

NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS AUTHORIZATION PERSONALLY.

_____

Student's Signature Birth date of Student, including year

_____

Name of Student's personal representative, if applicable

I am the Student's (check one): _____ Parent _____ Legal Guardian (documentation must be provided)

_____

Signature of Student's personal representative, if applicable Date

A copy of this signed form has been provided to the student or his/her personal representative.

Signature(s) above acknowledges that both the parents and students have all received the Ohio Detp. of Health Concussion Sheet, Sudden Cardiac Arrest Sheet, and have received the Mandatory OHSAA preseason meeting Info in regards to sportsmanship and eligibility. Student also agrees to abide by the Rules and Regulation in the Buckeye Local Code of Conduct. I also hereby consent to have my son/daughter/ward undergo urinalysis testing for the presence of drugs or alcohol in accordance with the Buckeye Local School District Drug and Alcohol Testing policy for Student/ Athletes.

PREPARTICIPATION PHYSICAL EVALUATION 2020-2021 OHSAA FORM 2 of 4

2020-2021 Ohio High School Athletic Association Eligibility and Authorization Statement

This document is to be signed by the participant from an OHSAA member school and by the participant's parent.

I have read, understand and acknowledge receipt of the **OHSAA Student Eligibility Guide and Checklist** https://www.ohsaa.org/Portals/0/Eligibility/OtherEligibiltyDocs/EligibilityGuideHS.pdf which contains a summary of the eligibility rules of the Ohio High School Athletic Association. I understand that a copy of the *OHSAA Handbook* is on file with the principal and athletic administrator and that I may review it, in its entirety, if I so choose. All OHSAA bylaws and regulations from the *Handbook* are also posted on the OHSAA website at ohsaa.org.

I understand that an OHSAA member school must **adhere to all rules and regulations** that pertain to the interscholastic athletics programs that the school sponsors, but that local rules may be more stringent than OHSAA rules.

I understand that participation in interscholastic athletics is a **privilege not a right**.

Student Code of Responsibility

As a student athlete, I **understand and accept** the following responsibilities:

- I will **respect the rights and beliefs** of others and will treat others with courtesy and consideration.
- I will be **fully responsible** for my own actions and the consequences of my actions.
- I will **respect the property** of others.
- I will **respect and obey the rules** of my school and laws of my community, state and country.
- I will **show respect to those who are responsible for enforcing the rules** of my school and the laws of my community, state and country.
- I **understand that a student whose character or conduct violates** the school's Athletic Code or School Code of Responsibility is not in good standing and is ineligible for a period as determined by the principal.

Informed Consent – By its nature, participation in interscholastic athletics includes risk of injury and transmission of infectious disease such as HIV and Hepatitis B. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants have a responsibility to help reduce that risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, GUARDIANS OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN AN OHSAA-SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN'S SIGNATURE.**

I understand that in the case of **injury or illness requiring treatment by medical personnel and transportation to a health care facility**, that a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be treated and transported via ambulance to the nearest hospital.

I consent to medical treatment for the student following an injury or illness suffered during practice and/or a contest.

To enable the OHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics in an OHSAA member school, I **consent to the release to the OHSAA any and all portions of school record files**, beginning with seventh grade, of the herein named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s)or guardian(s), enrollment documents, financial and scholarship records, residence address of the student, academic work completed, grades received and attendance data.

I consent to the OHSAA's use of the herein named student's name, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.

I understand that if I drop a class, take course work through College Credit Plus, Credit Flexibility or other educational options, this action could affect compliance with OHSAA academic standards and my eligibility. **I accept full responsibility** for compliance with Bylaw 4-4, Scholarship, and the passing five credit standard expressed therein.

I understand all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. Further I understand that if my student is removed from a practice or competition due to a suspected concussion, he or she will be unable to return to participation that day. After that day written authorization from a physician (M.D. or D.O.) or another health care provider working under the supervision of a physician will be required in order for the student to return to participation.

I have read and signed the Ohio Department of Health's **Concussion Information Sheet** and have retained a copy for myself.

I have read and signed the Ohio Department of Health's **Sudden Cardia Arrest Information Sheet** and have retained a copy for myself.

By signing this we acknowledge that we have read the above information and that we consent to the herein named student's participation.

***Must Be Signed Before Physical Examination**

_____

Student's Signature Birth date Grade in School Date

_____

Parent's or Guardian's Signature Date

Returning to Daily Activities

1. Be sure your child gets plenty of rest and enough sleep at night – no late nights. Keep the same bedtime weekdays and weekends.
2. Encourage daytime naps or rest breaks when your child feels tired or worn-out.
3. Limit your child's activities that require a lot of thinking or concentration (including social activities, homework, video games, texting, computer, driving, job-related activities, movies, parties). These activities can slow the brain's recovery.
4. Limit your child's physical activity, especially those activities where another injury or blow to the head may occur.
5. Have your qualified health care professional check your child's symptoms at different times to help guide recovery.

Returning to Learn (School)

1. Your athlete may need to initially return to school on a limited basis, for example for only half-days, at first. This should be done under the supervision of a qualified health care professional.
2. Inform teacher(s), school counselor or administrator(s) about the injury and symptoms. School personnel should be instructed to watch for:
   a. *Increased problems paying attention.*
   b. *Increased problems remembering or learning new information.*
   c. *Longer time needed to complete tasks or assignments.*
   d. *Greater irritability and decreased ability to cope with stress.*
   e. *Symptoms worsen (headache, tiredness) when doing schoolwork.*
3. Be sure your child takes multiple breaks during study time and watch for worsening of symptoms.
4. If your child is still having concussion symptoms, he/she may need extra help with school-related activities. As the symptoms decrease during recovery, the extra help or supports can be removed gradually.
5. For more information, please refer to Return to Learn on the ODH website.

Resources

ODH Violence and Injury Prevention Program
http://www.healthy.ohio.gov/vipp/child/returntoplay/

Centers for Disease Control and Prevention
http://www.cdc.gov/headsup/basics/index.html

National Federation of State High School Associations
www.nfhs.org

Brain Injury Association of America
www.biausa.org/

Returning to Play

1. Returning to play is specific for each person, depending on the sport. *Starting 4/26/13, Ohio law requires written permission from a health care provider before an athlete can return to play.* Follow instructions and guidance provided by a health care professional. It is important that you, your child and your child's coach follow these instructions carefully.
2. Your child should NEVER return to play if he/she still has ANY symptoms. (Be sure that your child does not have any symptoms at rest and while doing any physical activity and/or activities that require a lot of thinking or concentration).
3. Ohio law prohibits your child from returning to a game or practice on the same day he/she was removed.
4. Be sure that the athletic trainer, coach and physical education teacher are aware of your child's injury and symptoms.
5. Your athlete should complete a step-by-step exercise -based progression, under the direction of a qualified healthcare professional.
6. A sample activity progression is listed below. Generally, each step should take no less than 24 hours so that your child's full recovery would take about one week once they have no symptoms at rest and with moderate exercise.*

Sample Activity Progression*

***Step 1**: Low levels of non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: walking, light jogging, and easy stationary biking for 20-30 minutes).*

***Step 2**: Moderate, non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: moderate jogging, brief sprint running, moderate stationary biking, light calisthenics, and sport-specific drills without contact or collisions for 30-45 minutes).*

***Step 3**: Heavy, non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: extensive sprint running, high intensity stationary biking, resistance exercise with machines and free weights, more intense non-contact sports specific drills, agility training and jumping drills for 45-60 minutes).*

***Step 4**: Full contact in controlled practice or scrimmage.*

***Step 5**: Full contact in game play.*

***If any symptoms occur, the athlete should drop back to the previous step and try to progress again after a 24 hour rest period.**

Ohio Department of Health Concussion Information Sheet

For Interscholastic Athletics

Dear Parent/Guardian and Athletes,

This information sheet is provided to assist you and your child in recognizing the signs and symptoms of a concussion. Every athlete is different and responds to a brain injury differently, so seek medical attention if you suspect your child has a concussion. Once a concussion occurs, it is very important your athlete return to normal activities slowly, so he/she does not do more damage to his/her brain.

What is a Concussion?

A concussion is an injury to the brain that may be caused by a blow, bump, or jolt to the head. Concussions may also happen after a fall or hit that jars the brain. A blow elsewhere on the body can cause a concussion even if an athlete does not hit his/her head directly. Concussions can range from mild to severe, and athletes can get a concussion even if they are wearing a helmet.

Signs and Symptoms of a Concussion

Athletes do not have to be "knocked out" to have a concussion. In fact, less than 1 out of 10 concussions result in loss of consciousness. Concussion symptoms can develop right away or up to 48 hours after the injury. Ignoring any signs or symptoms of a concussion puts your child's health at risk!

Signs Observed by Parents of Guardians

- *Appears dazed or stunned.*
- *Is confused about assignment or position.*
- *Forgets plays.*
- *Is unsure of game, score or opponent.*
- *Moves clumsily.*
- *Answers questions slowly.*
- *Loses consciousness (even briefly).*
- *Shows behavior or personality changes (irritability, sadness, nervousness, feeling more emotional).*
- *Can't recall events before or after hit or fall.*

Symptoms Reported by Athlete

- *Any headache or "pressure" in head. (How badly it hurts does not matter.)*
- *Nausea or vomiting.*
- *Balance problems or dizziness.*
- *Double or blurry vision.*
- *Sensitivity to light and/or noise*
- *Feeling sluggish, hazy, foggy or groggy.*
- *Concentration or memory problems.*
- *Confusion.*
- *Does not "feel right."*
- *Trouble falling asleep.*
- *Sleeping more or less than usual.*

Be Honest

Encourage your athlete to be honest with you, his/her coach and your health care provider about his/her symptoms. Many young athletes get caught up in the moment and/or feel pressured to return to sports before they are ready. It is better to miss one game than the entire season… or risk permanent damage!

Seek Medical Attention Right Away

Seeking medical attention is an important first step if you suspect or are told your child has a concussion. A qualified health care professional will be able to determine how serious the concussion is and when it is safe for your child to return to sports and other daily activities.

- *No athlete should return to activity on the same day he/she gets a concussion.*
- *Athletes should NEVER return to practices/games if they still have ANY symptoms.*
- *Parents and coaches should never pressure any athlete to return to play.*

The Dangers of Returning Too Soon

Returning to play too early may cause Second Impact Syndrome (SIS) or Post-Concussion Syndrome (PCS). SIS occurs when a second blow to the head happens before an athlete has completely recovered from a concussion. This second impact causes the brain to swell, possibly resulting in brain damage, paralysis, and even death. PCS can occur after a second impact. PCS can result in permanent, long-term concussion symptoms. The risk of SIS and PCS is the reason why no athlete should be allowed to participate in any physical activity before they are cleared by a qualified healthcare professional.

Recovery

A concussion can affect school, work, and sports. Along with coaches and teachers, the school nurse, athletic trainer, employer, and other school administrators should be aware of the athlete's injury and their roles in helping the child recover.

During the recovery time after a concussion, physical and mental rest are required. A concussion upsets the way the brain normally works and causes it to work longer and harder to complete even simple tasks. Activities that require concentration and focus may make symptoms worse and cause the brain to heal slower. Studies show that children's brains take several weeks to heal following a concussion.

Ohio Department of Health

OHIO INJURY PREVENTION PARTNERSHIP
Injury Prevention Policy and Advocacy Action Group

http://www.healthy.ohio.gov/vipp/child/returntoplay/concussion
Rev. 09.16

Tear this page off. Its for you to keep.

Sudden Cardiac Arrest and Lindsay's Law

Parent/Athlete Signature Form

What is Lindsay's Law? Lindsay's Law is about Sudden Cardiac Arrest (SCA) in youth athletes. It covers all athletes 19 years or younger who practice for or compete in athletic activities. Activities may be organized by a school or youth sports organization.

Which youth athletic activities are included in Lindsay's law?

- Athletics at all schools in Ohio (public and non-public)
- Any athletic contest or competition sponsored by or associated with a school
- All interscholastic athletics, including all practices, interschool practices and scrimmages
- All youth sports organizations
- All cheerleading and club sports, including noncompetitive cheerleading

What is SCA? SCA is when the heart stops beating suddenly and unexpectedly. This cuts off blood flow to the brain and other vital organs. People with SCA will die if not treated immediately. SCA can be caused by 1) a structural issue with the heart, OR 2) an heart electrical problem which controls the heartbeat, OR 3) a situation such as a person who is hit in the chest or a gets a heart infection.

What is a warning sign for SCA? If a family member died suddenly before age 50, or a family member has cardiomyopathy, long QT syndrome, Marfan syndrome or other rhythm problems of the heart.

What symptoms are a warning sign of SCA? A young athlete may have these things with exercise:

- Chest pain/discomfort
- Unexplained fainting/near fainting or dizziness
- Unexplained tiredness, shortness of breath or difficulty breathing
- Unusually fast or racing heart beats

What happens if an athlete experiences syncope or fainting before, during or after a practice, scrimmage, or competitive play? The coach MUST remove the youth athlete from activity immediately. The youth athlete MUST be seen and cleared by a health care provider before returning to activity. This written clearance must be shared with a school or sports official.

What happens if an athlete experiences any other warning signs of SCA? The youth athlete should be seen by a health care professional.

Who can evaluate and clear youth athletes? A physician (MD or DO), a certified nurse practitioner, a clinical nurse specialist, certified nurse midwife. For school athletes, a physician's assistant or licensed athletic trainer may also clear a student. That person may refer the youth to another health care provider for further evaluation.

What is needed for the youth athlete to return to the activity? There must be clearance from the health care provider in writing. This must be given to the coach and school or sports official before return to activity.

All youth athletes and their parents/guardians must review information about Sudden Cardiac Arrest, then sign and return this form.

Keep This Form. Sign for it on the bottom of the OHSAA Authorization Form.

_____	_____
Parent/Guardian Signature	Student Signature
_____	_____
Parent/Guardian Name (Print)	Student Name (Print)
_____	_____
Date	Date

Ohio Department of Health | Ohio Department of Education

Ohio Department of Health Concussion Information Sheet

For Interscholastic Athletics

I have read the Ohio Department of Health's Concussion Information Sheet and understand that I have a responsibility to report my/my child's symptoms to coaches, administrators and healthcare provider.

I also understand that I/my child must have no symptoms before return to play can occur.

_____	_____
Athlete	Date
_____	**Keep This Form. Sign for it on the bottom of the OHSAA Authorization Form.**
Athlete *Please Print Name*	
_____	_____
Parent/Guardian	Date

Ohio Department of Health

Rev. 9.16

All Drug Testing **Must be done by** Corporate Health, Wheeling Hospital

BUCKEYE LOCAL SCHOOL DISTRICT
PARENT / GUARDIAN AND STUDENTS WHO ARE AT LEAST 18 YEARS OF AGE CONSENT TO PERFORM URINALYSIS FOR DRUG / ALCOHOL TESTING

Student Name: _____

Sport(s)/Activity: _____

I hereby consent to have my son/daughter/ward undergo urinalysis testing for the presence of drugs or alcohol in accordance with the Buckeye Local School District Drug and Alcohol Testing policy for Student/Athletes. I understand that this testing will occur according to the guidelines of the Buckeye Local Drug and Alcohol testing policy for Student/Athletes. I understand that any 'Urine samples taken for drug/alcohol testing will be sent only to a certified medical laboratory for actual testing. I hereby give my consent to the medical laboratory selected by the Buckeye Local Board of Education, its
doctors, employees, or agents together with any clinic, hospital, or laboratory designated by the selected medical laboratory, to perform urinalysis testing on my son/ daughter for the detection of drugs/alcohol.

I further give my permission to the medical laboratory selected by the Buckeye Local Board of Education, its doctors, employees, or agents, to release all results of these tests to the designated School District employees or agents if applicable. I understand that copies of the positive, inconclusive, adulterated or suspect results will also be made available to me.

This consent will be valid for a period of one year from date of execution.

I hereby release, waive, and discharge the Buckeye Local Board of Education, its individual members, employees, agents, and anyone acting on its behalf, from any and all liability claims, or causes of action arising from or related to the urinalysis drug/alcohol testing for extracurricular activity/athletic participation and/or the release of confidential medical information as authorized in this form and in the Drug and Alcohol
Testing Policy for Student/Athletes.

Parent/Guardian Signature: _____ Date:_____

Student Signature:_____ Date: _____

Date of Birth: _____
(Students over 18)

All Drug Testing **Must be done by** Corporate Health, Wheeling Hospital

BUCKEYE LOCAL SCHOOL DISTRICT
STUDENT CONSENT TO PERFORM URINALYSIS FOR DRUG / ALCOHOL TESTING
(FOR STUDENT'S UNDER 18 YEARS OLD)

I hereby consent to have my urine collected and tested for the presence of drugs or alcohol in accordance with the: Buckeye Local Drug and Alcohol Testing Policy for Student/Athletes.

I understand that this testing will occur in accordance to the guidelines of the Buckeye Local Drug and Alcohol Testing Policy for Student/Athletes.

I understand that any urine samples taken for drug/alcohol testing will be sent only to a certified medical laboratory for actual testing.

I hereby give my consent to the medical laboratory selected by the Buckeye Local Schools Board of Education, its doctors, employees, or agents together with any clinic, hospital, or laboratory designated by the selected medical laboratory, to perform urinalysis testing on me, for the detection of drugs/alcohol.

I further give my permission to the medical laboratory selected by the Buckeye Local Board of Education, its doctors, employees, or agents, to release all results of these tests to the designated School District employees or agents, if applicable. I understand that positive, adulterated, inconclusive or suspect results will also be made available to me and to my parent(s)/ guardian(s).

I hereby authorize the release of the results of such testing to my parent(s)/guardian's),
This consent shall be valid for one year from date of execution.

I hereby in conjunction with my parent/guardian consent and knowledge, release, waive, and discharge the Buckeye Local Board of Education, its individual members, employees, agents and anyone acting on its behalf, from any and all liability claims, or causes of action arising from or related to the urinalysis drug/alcohol testing for extracurricular activity/athletic participation and/or release of confidential medical information as authorized in this form and in the Drug and Alcohol Testing
Policy for Student/Athletes.

Student Athlete Signature:_____ Date:_____

Tear this page off. Its to be signed and turned in when taking your drug test.