

STUDENT ELIGIBILITY REQUIREMENTS

(Please read and sign before participating in any sport)

1. **PARENTS' PERMISSION FOR ATHLETIC PARTICIPATION:** Parents must sign the form, giving approval for their child to participate in interscholastic athletics. NO STUDENT WILL BE PERMITTED TO PRACTICE OR PARTICIPATE IN INTERSCHOLASTIC ATHLETICS WITHOUT PARENTS' CONSENT.
2. **PHYSICAL EXAMINATION CARD:** Parents are to complete the Health History side and sign the card. The doctor is to complete the physical examination and sign the card. NO STUDENT WILL BE PERMITTED TO PRACTICE OR PARTICIPATE IN AN INTERSCHOLASTIC ATHLETIC CONTEST WITHOUT HAVING BEEN GIVEN A PHYSICAL EXAMINATION AND APPROVAL BY A DOCTOR OF MEDICINE OR OSTEOPATHY.
3. **EMERGENCY CONSENT:** A parental signature on an Emergency Consent Form is required. NO STUDENT WILL BE ISSUED A PRACTICE PERMIT UNTIL HE/SHE HAS PRESENTED AN EMERGENCY CONSENT FORM, WHICH IS SIGNED BY A PARENT.
4. **ATHLETIC INSURANCE:** Before being permitted to practice or participate in an interscholastic athletic contest, a student must be covered by their parents' insurance or student activity insurance. Student activity insurance information is available in the office.
5. **BIRTH CERTIFICATE:** Students who have not previously presented a birth certificate to the office for recording must do so. Students, who have reached the age of 15 prior to September 1, are ineligible to compete in junior high athletic contests.
6. **ACADEMIC ELIGIBILITY:** A student must be passing all subjects at grade check time in order to be academically eligible to compete in athletic contests.
7. **ATHLETIC PRACTICE PERMIT:** The Assistant Principal's office shall issue an Athletic Practice Permit to the student when all eligibility requirements have been verified and recorded. Until the ATHLETIC PRACTICE PERMIT is completed and signed by the Assistant Principal and is presented to the coach, no equipment of any kind shall be issued to the student nor shall he/she be permitted to practice or participate in interscholastic athletics.
8. **PAY TO PLAY CONTRACT:** The contract must be signed by the parent, student, and coach and turned into the Assistant Principal's office prior to the student being given an ATHLETIC PRACTICE PERMIT and being permitted to practice or participate in interscholastic athletic contest.
9. **PAY TO PLAY FEE:** The fee (check, cash, or tax credit form with money) must be turned into the Assistant Principal's office prior to the first interscholastic contest.

I/We affirm that I/we have read the above Eligibly requirements for Athletic Participation.

Parent/Guardian Signature

Student's Signature

Date

ATHLETIC PARTICIPATION PERMISSION FORM

(EMERGENCY, INSURANCE and PARENT CONSENT)

Name _____ Birth date _____ Male / Female _____
Address _____ Home phone _____ Grade _____
Father/guardian _____ Work phone _____ Cell _____
Mother/guardian _____ Work phone _____ Cell _____
Name of persons who could assume temporary responsibility in case of emergency or illness:
Local friend/relative _____ Phone _____

Parent or Guardian Permission: I/We give our permission for the above named student to participate in organized Junior High School Athletics, realizing that such activity involves the potential for injury and/or transmittable diseases which are inherent in all sports. I/We acknowledge that even with qualified coaching, use of approved equipment, and strict observance of the rules, injuries or transmittable diseases are still a possibility.

Consent for Emergency Care: Be it known that I, the undersigned parent or guardian of the above named student, do hereby give and grant unto any medical doctor or hospital *selected by the school* my consent and authorization to render such aid, treatment or care to said student, *if neither the parents or guardians can be contacted*, in the judgment of the said doctor or hospital, on an emergency basis, in the event said student should be injured or stricken ill while participating in an interscholastic activity.

IT IS HEREBY understood that the consent and authorization hereby given and granted are continuing and intended by me to extend throughout the school year.

IT IS FURTHER understood that any expenses incurred will be paid for by the insurance or the parent of the student. Payment of any medical expense is not a school responsibility.

STATEMENT OF INSURANCE COVERAGE (Check either Option #1,#2 or #3)

_____ **OPTION #1:** I/We affirm that I/We am/are the parent(s) of the legal guardian(s) of the above named student. I/We certify that the above named student is currently covered and will be covered during the present school year by an accident insurance policy which includes coverage in the event of injury in a school supervised game or activity.

Health Insurance (name): _____ **Policy#:** _____

_____ **OPTION #2:** I/We desire to purchase student activity insurance through the school. FORMS ARE AVAILABLE IN THE OFFICE.

_____ **OPTION #3:** I/We do not desire to have insurance coverage. **Any expenses incurred as a result of injury will be the responsibility of the parent.**

RESPONSIBILITY FOR EQUIPMENT RETURN: I/We agree to be responsible for the safe return of all athletic and/or activity equipment issued by the school to the above named student.

I/WE HAVE READ, UNDERSTAND, AND AGREE TO ALL OF THE ABOVE STATEMENTS AND CONDITIONS

Parent/Guardian's Signature

Student's Signature

Date

Exam Date _____



ARIZONA INTERSCHOLASTIC ASSOCIATION

7007 North 18th Street, Phoenix, Arizona 85020-5552

Phone: (602) 385-3810

2014-2015 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The Parent or Guardian should fill out this form with assistance from the student athlete.)

Name _____ Sex _____ Age _____ Date of Birth _____ Grade _____

School _____ Sport(s) _____

Address _____ Phone _____

Personal Physician _____ Hospital Preference _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H): _____ (W): _____ (C) _____

Name _____ Relationship _____ Phone (H): _____ (W): _____ (C) _____

Explain "Yes" answers below.

Circle questions you don't know the answers to.

	YES	NO		YES	NO
1) Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	18) Have you ever used an inhaler or taken asthma medication?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	19) Were you born without, are you missing. Or do you have a nonfunctioning kidney, eye, testicle or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>
3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (<i>Please specify</i>):	<input type="checkbox"/>	<input type="checkbox"/>	20) Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>
4) Do you have allergies to medicines, pollens, foods, or stinging insects? (<i>Please specify</i>):	<input type="checkbox"/>	<input type="checkbox"/>	21) Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
5) Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	22) Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>
6) Has a doctor ever told you that you have (<i>check all that apply</i>):	<input type="checkbox"/>	<input type="checkbox"/>	23) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	24) Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection	<input type="checkbox"/>	<input type="checkbox"/>	25) Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7) Have you ever spent the night in the hospital?	<input type="checkbox"/>	<input type="checkbox"/>	26) Have you ever had numbness, tingling, or weakness in your arms or legs after being hit, falling, stingers or burners?	<input type="checkbox"/>	<input type="checkbox"/>
8) Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	27) When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>
* 9) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (<i>If yes, circle affected area in the box below</i>):	YES <input type="checkbox"/>	NO <input type="checkbox"/>	28) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>
* 10) Have you had any broken/fractured bones or dislocated joints? (<i>If yes, circle affected area in the boxes below</i>):	<input type="checkbox"/>	<input type="checkbox"/>	29) Have you ever been tested for sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>
* 11) Have you had a bone/joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? (<i>If yes, circle affected area in the boxes below</i>):	<input type="checkbox"/>	<input type="checkbox"/>	30) Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Upper Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm			31) Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand/Fingers <input type="checkbox"/> Chest <input type="checkbox"/> Upper Back <input type="checkbox"/> Low Back <input type="checkbox"/> Hip <input type="checkbox"/> Thigh			32) Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Knee <input type="checkbox"/> Calf/Shin <input type="checkbox"/> Ankle <input type="checkbox"/> Foot/Toes			33) Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>
12) Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	34) Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
13) Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	35) Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>
14) Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	36) Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
15) Has a doctor told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>	37) Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
16) Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>			
17) Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>			

FEMALES ONLY

YES NO

38) Have you ever had a menstrual period?

☐ ☐

39) How old were you when you had your first menstrual period?

40) How many periods have you had in the last year?

Explain "Yes" answers here:



2014-2015 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The Physician should fill out this form with assistance from the Parent or Guardian.)

Student Name: _____

Date of Birth: _____

Patient History Questions: Please tell me about your child....		YES	NO
1) Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?		<input type="checkbox"/>	<input type="checkbox"/>
2) Has your child ever had extreme shortness of breath during exercise?		<input type="checkbox"/>	<input type="checkbox"/>
3) Has your child had extreme fatigue associated with exercise (different from other children)?		<input type="checkbox"/>	<input type="checkbox"/>
4) Has your child ever had discomfort, pain or pressure in his/her chest during exercise?		<input type="checkbox"/>	<input type="checkbox"/>
5) Has a doctor ever ordered a test for your child's heart?		<input type="checkbox"/>	<input type="checkbox"/>
6) Has your child ever been diagnosed with an unexplained seizure disorder?		<input type="checkbox"/>	<input type="checkbox"/>
7) Has your child ever been diagnosed with exercised -induced asthma not well controlled with medication?		<input type="checkbox"/>	<input type="checkbox"/>
Family History Questions: Please tell me about any of the following in your family....		YES	NO
8) Are there any family members who had sudden, unexpected, unexplained death before age 50? (including SIDS, car accidents, drowning, or near drowning)		<input type="checkbox"/>	<input type="checkbox"/>
9) Are there any family members who died suddenly of "heart problems" before age 50?		<input type="checkbox"/>	<input type="checkbox"/>
10) Are there any family members who have unexplained fainting or seizures?		<input type="checkbox"/>	<input type="checkbox"/>
11) Are there any relatives with certain conditions, such as:			
Enlarged Heart:			
	Hypertrophic Cardiomyopathy (HCM)	<input type="checkbox"/>	<input type="checkbox"/>
	Dilated Cardiomyopathy (DCM)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rhythm problems:		<input type="checkbox"/>	<input type="checkbox"/>
	Long QT Syndrome (LQTS)	<input type="checkbox"/>	<input type="checkbox"/>
	Short QT Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
	Brugada Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
	Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	<input type="checkbox"/>	<input type="checkbox"/>
	Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	<input type="checkbox"/>	<input type="checkbox"/>
Marfan Syndrome (Aortic Rupture)		<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack, age 50 or younger		<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker or Implanted Defibrillator		<input type="checkbox"/>	<input type="checkbox"/>
Deaf at Birth (Congenital Deafness)		<input type="checkbox"/>	<input type="checkbox"/>

Explain "Yes" answers here:

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

Signature of athlete: _____

Signature of parent/guardian: _____

Date: _____

Signature of MD/DO/NP/PA-C: _____

Date: _____

FORM 15.7-A 02/14

2014-15 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

Name _____ Date of birth _____ Age _____ Sex _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____ BP ____ / ____ (____ / ____, ____ / ____)

Vision R 20 / ____ L 20 / ____ Corrected: Y N Pupils: Equal ____ Unequal ____

	NORMAL	ABNORMAL FINDINGS	INITIALS *
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Hearing			
Lymph Nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary †			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

* Multi-examiner set-up only.

† Having a third party present is recommended for the genitourinary examination.

Notes: _____

☐ Cleared without restriction

☐ Not cleared for: ☐ All sports ☐ Certain sports: _____ Reason: _____

Recommendations: _____

Name of physician (print/type) _____ Exam Date _____

Address _____ Phone _____

Signature of physician _____, MD / DO / NP / PA-C



Arizona Interscholastic Association, Inc.

Mild Traumatic Brain Injury (MTBI) / Concussion

Annual Statement and Acknowledgement Form

I, _____ (student), acknowledge that I have to be an active participant in my own health and have the direct responsibility for reporting all of my injuries and illnesses to the school staff (e.g., coaches, team physicians, athletic training staff). I further recognize that my physical condition is dependent upon providing an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced before, during or after athletic activities.

By signing below, I acknowledge:

- My institution has provided me with specific educational materials including the CDC Concussion fact sheet (<http://www.cdc.gov/concussion/HeadsUp/youth.html>) on what a concussion is and has given me an opportunity to ask questions.
- I have fully disclosed to the staff any prior medical conditions and will also disclose any future conditions.
- There is a possibility that participation in my sport may result in a head injury and/or concussion. In rare cases, these concussions can cause permanent brain damage, and even death.
- A concussion is a brain injury, which I am responsible for reporting to the team physician or athletic trainer.
- A concussion can affect my ability to perform everyday activities, and affect my reaction time, balance, sleep, and classroom performance.
- Some of the symptoms of concussion may be noticed right away while other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I am responsible for reporting the injury to the school staff.
- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
- I will not return to play in a game or practice until my symptoms have resolved AND I have written clearance to do so by a qualified health care professional.
- Following concussion the brain needs time to heal and you are much more likely to have a repeat concussion or further damage if you return to play before your symptoms resolve.

Based on the incidence of concussion as published by the CDC the following sports have been identified as high risk for concussion; baseball, basketball, diving, football, pole vaulting, soccer, softball, spiritline and wrestling.

I represent and certify that I and my parent/guardian have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be bound by this document.

Student Athlete:

Print Name: _____ Signature: _____

Date: _____

Parent or legal guardian must print and sign name below and indicate date signed.

Print Name: _____ Signature: _____

Date: _____



A Fact Sheet for PARENTS

WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury. Concussions are caused by a bump or blow to the head. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

You can’t see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

WHAT ARE THE SIGNS AND SYMPTOMS OF A CONCUSSION?

Signs Observed by Parents or Guardians

If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs and symptoms of a concussion:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes

Symptoms Reported by Athlete

- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just “not feeling right” or “feeling down”

HOW CAN YOU HELP YOUR CHILD PREVENT A CONCUSSION OR OTHER SERIOUS BRAIN INJURY?

- Ensure that they follow their coach’s rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.
- Make sure they wear the right protective equipment for their activity. Protective equipment should fit properly and be well maintained.
- Wearing a helmet is a must to reduce the risk of a serious brain injury or skull fracture.
 - However, helmets are not designed to prevent concussions. There is no “concussion-proof” helmet. So, even with a helmet, it is important for kids and teens to avoid hits to the head.

WHAT SHOULD YOU DO IF YOU THINK YOUR CHILD HAS A CONCUSSION?

1. SEEK MEDICAL ATTENTION RIGHT AWAY.

A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to regular activities, including sports.

2. KEEP YOUR CHILD OUT OF PLAY.

Concussions take time to heal. Don’t let your child return to play the day of the injury and until a health care professional says it’s OK. Children who return to play too soon—while the brain is still healing—risk a greater chance of having a repeat concussion. Repeat or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.

3. TELL YOUR CHILD’S COACH ABOUT ANY PREVIOUS CONCUSSION.

Coaches should know if your child had a previous concussion. Your child’s coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

It’s better to miss one game than the whole season.

For more information, visit www.cdc.gov/Concussion.



Hoja Informativa para los PADRES

¿QUÉ ES LA CONMOCIÓN CEREBRAL?

Una conmoción cerebral es una lesión en el cerebro, causada por un golpe en la cabeza o una sacudida. Incluso una pequeña conmoción o lo que parece ser un golpe o sacudida leve puede ser serio.

La conmoción cerebral no puede verse. Los signos y síntomas de una conmoción pueden aparecer inmediatamente después de la lesión o puede que no aparezcan, o se hagan visibles algunos días o meses después de haber sufrido la lesión. Si su hijo tiene los signos de una conmoción cerebral o si usted nota algún síntoma, busque atención médica de inmediato.

¿CUÁLES SON LOS SIGNOS Y SÍNTOMAS DE LA CONMOCIÓN CEREBRAL?

Signos que notan los padres y los tutores

Si su hijo ha sufrido un golpe en la cabeza o una sacudida durante un juego o una práctica, obsérvelo para determinar si tiene alguno de los siguientes signos y síntomas de una conmoción cerebral:

- Luce aturdido o fuera de control
- Se confunde con la actividad asignada
- Olvida las jugadas
- No se muestra seguro del juego, la puntuación ni de sus adversarios
- Se mueve con torpeza
- Responde con lentitud
- Pierde el conocimiento (así sea momentáneamente)
- Muestra cambios de conducta o de personalidad
- No puede recordar lo ocurrido antes de un lanzamiento o un caída
- No puede recordar lo ocurrido después de un lanzamiento o un caída

Síntomas que reporta el atleta

- Dolor o "presión" en la cabeza
- Náuseas o vómitos
- Problemas de equilibrio, mareo
- Visión doble o borrosa
- Sensibilidad a la luz y al ruido
- Se siente débil, confuso, aturdido o grogui
- Problemas de concentración o memoria
- Confusión
- No se "siente bien"

¿CÓMO AYUDAR A SU HIJO A PREVENIR UNA CONMOCIÓN CEREBRAL?

Aunque todo deporte es diferente, hay medidas que puede tomar para protegerse.

- Haga que siga las reglas impartidas por el entrenador y las reglas del deporte que practica.
- Invítelo a mantener el espíritu deportivo en todo momento.
- Haga que su hijo use el equipo protector adecuado según la actividad que realiza. El equipo de protección debe ajustarse bien, debe hacerse el mantenimiento adecuado, y el jugador debe usarlo correctamente y en todo momento.

¿QUÉ DEBE HACER SI CREE QUE SU HIJO HA SUFRIDO UNA CONMOCIÓN CEREBRAL?

- 1. Busque atención médica de inmediato.** Un profesional de la salud podrá determinar la seriedad de la conmoción cerebral que ha sufrido el niño y cuándo podrá regresar al juego sin riesgo alguno.
- 2. No permita que su hijo siga jugando.** Las conmociones cerebrales necesitan de un cierto tiempo para curarse. No permita que su hijo regrese al juego hasta que un profesional de la salud le haya dicho que puede hacerlo. Los niños que regresan al juego antes de lo debido—mientras el cerebro está en proceso de curación—corren un mayor riesgo de sufrir otra conmoción. Las conmociones cerebrales siguientes pueden ser muy serias. Pueden causar daño cerebral permanente que afectarán al niño de por vida.
- 3. Informe al entrenador del niño sobre cualquier conmoción cerebral que el niño haya sufrido recientemente.** Los entrenadores deben saber si el niño ha sufrido una conmoción recientemente en CUALQUIER deporte. El entrenador no necesariamente sabrá si el niño ha tenido una conmoción en otro deporte o actividad a menos que usted se lo diga.

Es preferible perderse un juego que toda la temporada.

Para obtener más información, visite www.cdc.gov/ConcussionInYouthSports.



A QUIZ FOR COACHES, ATHLETES, AND PARENTS

Review the “Heads Up: Concussion in Youth Sports” materials and test your knowledge of concussion.

Mark each of the following statements as True (T) or False (F)

1. A concussion is a brain injury.
2. Concussions can occur in any organized or unorganized recreational sport or activity.
3. You can't see a concussion and some athletes may not experience and/or report symptoms until hours or days after the injury.
4. Following a coach's rules for safety and the rules of the sport, practicing good sportsmanship at all times, and using the proper sports equipment are all ways that athletes can prevent a concussion.
5. Concussions can be caused by a fall or by a bump or blow to the head or body.
6. Concussion can happen even if the athlete hasn't been knocked out or lost consciousness.
7. Nausea, headaches, sensitivity to light or noise, and difficulty concentrating are some of the symptoms of a concussion.
8. Athletes who have a concussion should not return to play until they are symptom-free and have received approval from a doctor or health care professional.
9. A repeat concussion that occurs before the brain recovers from the first can slow recovery or increase the likelihood of having long-term problems.

ANSWER KEY: 1. True; 2. True; 3. True; 4. True; 5. True; 6. True; 7. True; 8. True; 9. True

It's better to miss one game than the whole season.

For more information and to order additional materials **free-of-charge**, visit:

www.cdc.gov/ConcussionInYouthSports