

BOSTON PUBLIC SCHOOLS



DEPARTMENT OF ATHLETICS

May 2016

Welcome to Boston Public Schools Athletics! Thank you for your interest and commitment to participating in the athletics program for the 2016-2017 seasons. Athletic participation is based on satisfying all MIAA, Boston Public Schools and specific school rules, policies and procedures around athletics.

Fall Sports: Cheerleading, Cross Country, Football, Boys'/Girls' Soccer, Volleyball

Winter Sports: Boys'/Girls' Basketball, Boys'/Girls' Hockey, Indoor Track, Swimming, Wrestling

Spring Sports: Baseball, Outdoor Track, Softball, Boys'/Girls' Tennis, Boys' Volleyball

	First Practice	First Game
Fall Season	8/19/16(FB), 8/25/16	9/8/16, 9/9/16(FB),
Winter Season	11/28/16	12/8/16
Spring Season	3/20/17	3/29/17

The following attachment contains all pertinent forms required for participation in Boston Public Schools Athletics. All forms must be signed and accurately completed to the best of your knowledge prior to the start of practice.

Forms to be Completed and Returned:

1. Sports Physical Form (must be completed every 13 months)
2. Medical Questionnaire (must be completed each season)
3. Parental Consent Form
4. Massachusetts Concussion Reporting Form
5. Concussion Information Form

BPS Requirements for Athletic Participation:

- 1.67 GPA or Higher (the GPA requirement may be higher at some schools)
- School attendance of 93% or higher
- Updated physical in the last 13 months
- Completed physical, parental consent and concussion forms
- MIAA Age Requirement- A student who is 19 years of age prior to September 1 is not eligible for high school athletic participation. (Student-athletes can appeal this rule to the MIAA)

If you have any questions, or need any additional information, please contact your Athletic Coordinator or the BPS Athletics Department.

Sincerely,

Avery Esdaile
Boston Public Schools
Director of Athletics

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____ (_____ / _____)	Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart ^a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) ^b		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic ^c		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

- Not cleared
- Pending further evaluation
- For any sports
- For certain sports _____
- Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Boston Public Schools

MEDICAL QUESTIONNAIRE

This form must be completed by parents and returned to the coach along with the physical examination form completed by a physician, or medical equivalent.

Student Name: _____ Sex: _____ D.O.B.: _____ Gr. _____

School: _____ Coach: _____

The following information is for review by the school nurse, for the purpose of optimizing safe sports participation. Please indicate Y (yes), N (no), DK (don't know).

1	Have you had a medical illness or injury since your last check up or sports physical?		19	Have you ever been knocked out, become unconscious, or lost your memory?	
2	Have you ever been hospitalized overnight?		20	Have you ever has a seizure?	
3	Have you ever had surgery?		21	Do you have frequent or sever headaches?	
4	Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?		22	Have you ever had numbness or tingling in your arms, hands, legs, or feet?	
5	Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?		23	Have you ever had a stinger, burner, or pinched nerve?	
6	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?		24	Have you ever become ill from exercising in heat?	
7	Have you ever had a rash or hives develop during or after exercise?		25	Do you cough, wheeze, or have trouble breathing during or after exercising?	
8	Have you ever passed out during or after exercise?		26	Do you have Asthma?	
9	Have you ever been dizzy during or after exercise?		27	Do you have seasonal allergies that require medical treatment?	
10	Have you ever had chest pain during or after exercise?		28	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	
11	Do you get tired more quickly than your friends do during exercise?		29	Have you had any problems with your eyes or vision?	
12	Have you ever had racing of your heart or skipped heartbeat?		30	Do you wear glasses, contacts, or protective eyewear?	
13	Have you had high blood pressure or high cholesterol?		31	Have you ever had a sprain, strain, or swelling after injury?	
14	Have you ever been told you have a heart murmur? If yes, please explain.		32	Have you broken or fractured any bones or dislocated any joints?	
15	Has any family member or relative died of heart problems or of sudden death before age 50?		33	Have you had any other problems with pain or swelling in muscles, tendons. Bones, or joints? If yes, circle and explain on back side of this questionnaire: Head , Elbow, Forearm, Wrist, Hand, Upper Arm, Hip, Thigh, Knee, Shin/Calf, Foot, Head, Neck, Back, or Chest?	
16	Has a physician ever denied or restricted your participation in sports for any heart problems?		34	Do you want to weigh more or less than you do now?	
17	Do you have any current skin problems (for example) itching, rashes, acne, warts, fungus, or blisters)?		36	Do you lose weight regularly to meet weight requirements for your sport?	
18	Have you ever had a head injury or concussion? How many? _____. What was the longest duration of symptoms? ____days, ____ weeks, ____ months, ____ years			Explanations of "yes" responses: (attach any documentation necessary.	

Parent Signature: _____ Date: _____

STUDENT PARTICIPATION PARENTAL CONSENT FORM

School:		School Year:
Last Name:	First Name:	Student #
Address		
City/Town:	State:	Zip:
Parent/ Guardian # 1:	Parent Guardian 2:	
Home Phone:	Home Phone:	
Cell Phone:	Cell Phone:	

Emergency Contact Information

Name:		
Phone Contacts: (Cell)	(Home)	(Work)

Relationship to Student:

SPORTS PARTICIPATION: Please select each sport in which you intend to participate.

BPS HIGH SCHOOLS OFFERINGS			BPS MS + K8 OFFERINGS	Others (Please record)
Fall	Winter	Spring	Baseball	
Football	Basketball	Baseball	Basketball	
Cross Country	Indoor Track	Softball	Double Dutch	
Volleyball	Ice Hockey	Tennis	Football	
Soccer	Swimming	Outdoor Track	Track + Field	
Cheer	Wrestling	Volleyball	Volleyball	

Both the student and parent/guardian must read carefully and sign below**MEDICAL QUESTIONNAIRE and PHYSICAL EXAMINATIONS**

I hereby state to the best of my knowledge, my answers to the sports medical questionnaire are complete and correct and submitted to my child's school nurse along with a current (13 months) physical examination document. I give permission for my child to participate in Boston Public Schools athletic programs. Boston Public Schools and its athletic trainers and associated medical personnel have permission to seek necessary emergency medical treatment for my child during his/her participation in conditioning, practices, play, and play competitions in any and all above-checked athletics teams, activities, and programs.

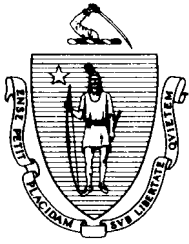
HOLD HARMLESS AGREEMENT and EMERGENCY/INJURY TREATMENT or CARE

I acknowledge that there are many inherent RISKS of INJURY involved in participating in athletic events. In acknowledging these RISKS (including, but not limited to injuries to vital joints, ligaments, tendons, organs, muscles, bones, as well as head injuries, neck and spinal injuries, partial paralysis, brain damage, and even death) and in consideration of the opportunity for my child to participate in the above checked sport(s), I agree to hold Boston Public Schools collectively and individually, its employees, agents, representatives, medical personnel, coaches, and volunteers, including managers and athletic trainers, harmless from any and all liability, actions, causes of actions, debts, claims, or demands of any kind and nature whatsoever (including attorney fees) which may arise by or in connection with my child's participation. The terms hereof shall serve as a release and assumption of risk for my heirs, estate, executor, administrators, assignees, and for all members of my family. If needed, I hereby authorize dispensation of medication by non-nursing personnel as provided by my child's medical provider.

CONCUSSION AWARENESS

I understand that Massachusetts State Laws requires parents, guardians, volunteers and parent volunteers of participating student athletes in any Boston Public school athletic activity, team, program, or event, to participate in SPORT/HEAD INJURIES and CONCUSSION AWARENESS (online or through written materials) training. By my signature I attest I have completed the training.

Signature (Parent/Guardian):	Date:
Signature (Student):	Date:



The Commonwealth of Massachusetts
 Executive Office of Health and Human Services
 Department of Public Health
 250 Washington Street, Boston, MA 02108-4619

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JOHN AUERBACH
COMMISSIONER

**PRE-PARTICIPATION HEAD
 INJURY/CONCUSSION REPORTING FORM
 FOR EXTRACURRICULAR ACTIVITIES**

This form should be completed by the student's parent(s) or legal guardian(s). It must be submitted to the Athletic Director, or official designated by the school, *prior* to the start of each season a student plans to participate in an extracurricular athletic activity.

Student's Name	Sex	Date of Birth	Grade
School		Sport(s)	
Home Address			Telephone

Has student ever experienced a traumatic head injury (a blow to the head)? Yes _____ No _____

If yes, when? Dates (month/year): _____

Has student ever received medical attention for a head injury? Yes _____ No _____

If yes, when? Dates (month/year): _____

If yes, please describe the circumstances:

Was student diagnosed with a concussion? Yes _____ No _____

If yes, when? Dates (month/year): _____

Duration of Symptoms (such as *headache, difficulty concentrating, fatigue*) for most recent concussion: _____

Parent/Guardian:

Name: _____ Signature/Date _____
 (Please print)

Student Athlete:

Signature/Date _____



Parent/Athlete Concussion Information Sheet

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by bump, blow, or jolt to the head or body that causes the head and brain to move rapidly back and forth. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

WHAT ARE THE SIGNS AND SYMPTOMS OF 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 an athlete reports **one or more** symptoms of concussion listed below after a bump, blow, or jolt to

Did You Know?

- Most concussions occur *without* loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

the head or body, s/he should be kept out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it’s OK to return to play.

SIGNS OBSERVED BY COACHING STAFF	SYMPTOMS REPORTED BY ATHLETES
Appears dazed or stunned	Headache or “pressure” in head
Is confused about assignment or position	Nausea or vomiting
Forgets an instruction	Balance problems or dizziness
Is unsure of game, score, or opponent	Double or blurry vision
Moves clumsily	Sensitivity to light
Answers questions slowly	Sensitivity to noise
Loses consciousness (<i>even briefly</i>)	Feeling sluggish, hazy, foggy, or groggy
Shows mood, behavior, or personality changes	Concentration or memory problems
Can’t recall events <i>prior</i> to hit or fall	Confusion
Can’t recall events <i>after</i> hit or fall	Just not “feeling right” or “feeling down”

CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that not only does not diminish, but gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (*even a brief loss of consciousness should be taken seriously*)

WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. *They can even be fatal.*

Remember

Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

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

If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.

Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

It's better to miss one game than the whole season. For more information on concussions, visit: www.cdc.gov/Concussion.

Student-Athlete Name Printed

Student-Athlete Signature

Date

Parent or Legal Guardian Printed

Parent or Legal Guardian Signature

Date