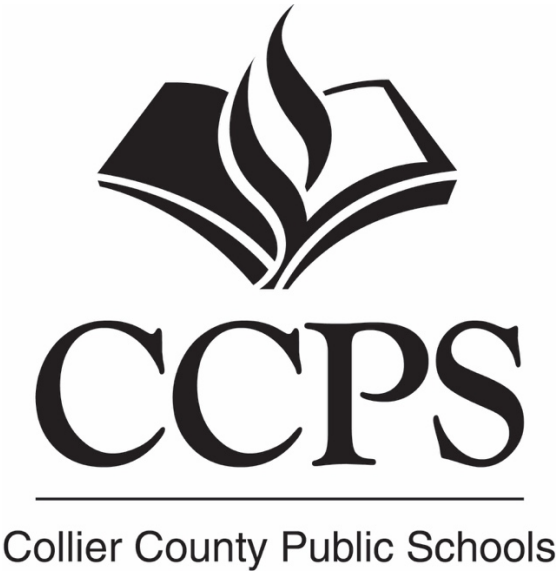

High School Marching Band

Medical Information Forms

*** This form does not replace the FHSAA forms for Athletic clearance. A band student wishing to compete in high school athletics must comply with any required medical documentation as per the Activities office and CCPS policy ***

Concussion Guidelines & Information

Concussion Information

What is a concussion?

Concussion is a brain injury. Concussions are most often caused by a sudden direct blow or bump to the head.

The brain is made of soft tissue, cushioned by spinal fluid, and encased by the skull. An impact to the head can jolt your brain causing a concussion. Traumatic brain injuries, such as a concussion, can cause bruising, damage to the blood vessels, and injury to the nerves. If you have suffered a concussion, possible indicators are (but not limited to): vision disturbance, loss of equilibrium, or you may fall unconscious. NOTE: more than 90% of all concussions occur without loss of consciousness.

Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. All concussions are potentially serious and, if not managed properly, may result in complications including brain damage and, in rare cases, even death.

If your student reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, your child/ward should be immediately removed from strenuous activity, evaluated by a medical professional, and cleared by a medical doctor.

What are the signs and symptoms of concussion?

Concussion symptoms may appear immediately after the injury or can take several days to appear. Studies have shown that it takes on average 10-14 days or longer for symptoms to resolve and, in rare cases or if the student has sustained multiple concussions, the symptoms can be prolonged. Signs and symptoms of concussion can include: (not all-inclusive)

- Vacant stare or seeing stars
- Lack of awareness of surroundings
- Emotions out of proportion to circumstances (inappropriate crying or anger)
- Headache or persistent headache, nausea, vomiting
- Altered vision
- Sensitivity to light or noise
- Delayed verbal and motor responses
- Disorientation, slurred or incoherent speech
- Dizziness, including light-headedness, vertigo (spinning) or loss of equilibrium (being off balance or swimming sensation)
- Decreased coordination, reaction time
- Confusion and inability to focus attention
- Memory loss
- Sudden change in academic performance or drop in grades
- Irritability, depression, anxiety, sleep disturbances, easy fatigability
- In rare cases, loss of consciousness

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What can happen if my child/ward continues to participate with a concussion or returns too soon?

Students with signs and symptoms of concussion must be removed from activity (play or practice) immediately. Continuing to participate with the signs and symptoms of a concussion leaves them vulnerable to sustaining another concussion. Students who sustain a second concussion before the symptoms of the first concussion have resolved and the brain has had a chance to heal are at risk for prolonged concussion symptoms, permanent disability and even death (called "Second Impact Syndrome" where the brain swells uncontrollably). There is also evidence that multiple concussions can lead to long-term symptoms, including early dementia.

What do I do if I suspect my child/ward has suffered a concussion?

Any student suspected of suffering a concussion must be removed from the activity immediately. No student may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without written medical clearance from an appropriate health-care professional (AHCP). In Florida, an appropriate health-care professional (AHCP) is defined as either a licensed physician (MD, as per Chapter 458, Florida Statutes), a licensed osteopathic physician (DO, as per Chapter 459, Florida Statutes), or a licensed physicians assistant under the direct supervision of a MD/DO (as per Chapters 458 and 459, Florida Statutes). Close observation of the student should continue for several hours. You should also seek medical care and inform your child/ward's responsible teacher if you think that your child/ward may have a concussion. Remember, it's better to miss one day than to have their life changed forever. When in doubt, sit them out.

When can my child/ward return to play or practice?

Following physician evaluation, the return to activity process requires the student to be completely symptom free, after which time they would complete a step-wise protocol under the supervision of a licensed athletic trainer, coach or medical professional and then receive written medical clearance of an AHCP.

For current and up-to-date information on concussions, visit
http://www.cdc.gov/concussioninyouthsports/ or http://www.seeingstarsfoundation.org

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Statement of Student Responsibility

I understand that my child accepts responsibility for reporting all injuries and illnesses to their parents/guardians, doctor, staff, or teachers associated with their activity including any signs and symptoms of concussion. My child/ward and I have read and understood the above information on concussion. My child/ward will inform the supervising teacher, staff, or parent immediately if they experience any of these symptoms or witness a teammate with these symptoms. Furthermore, I have been advised of the dangers of participation for my child/ward.

_____	_____	____/____/_____
Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date

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Heat-Related Illness Guidelines & Information

Heat-Related Illnesses Information

People suffer heat-related illness when their bodies cannot properly cool themselves by sweating. Sweating is the body's way of cooling itself, but when a person's body temperature rises rapidly, sweating is not enough. Heat-related illnesses can be serious and life threatening. Very high body temperatures may damage the brain or other vital organs, and can cause disability and even death. Heat-related illnesses and deaths are preventable.

Heat Stroke is the most serious heat-related illness. It happens when the body's temperature rises quickly and the body cannot cool down. Heat Stroke can cause permanent disability and death.

Heat Exhaustion is a milder type of heat-related illness. It usually develops after a number of days in high temperature weather and not drinking enough fluids (water). Heat Cramps usually affect people who sweat a lot during demanding activity. Sweating reduces the body's salt and moisture and can cause painful cramps, usually in the abdomen, arms, or legs. Heat cramps may also be a symptom of heat exhaustion.

Young and healthy individuals can succumb to heat if they participate in demanding physical activities during hot weather. Other conditions that can increase your risk for heat-related illness include obesity, fever, dehydration, poor circulation, sunburn, and prescription drug or alcohol use.

Symptoms of heat-related illness may include:

- Fainting (Unconsciousness)
- Throbbing headache
- Dizziness and light-headedness
- Lack of sweating despite the heat
- Red, hot, and dry skin
- Muscle weakness or cramps
- Nausea and vomiting
- Rapid heartbeat, which may be either strong or weak
- Rapid, shallow breathing
- Behavioral changes such as confusion, disorientation, or staggering
- Seizures

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Statement of Student Responsibility

I understand that my child accepts responsibility for reporting all injuries and illnesses to their parents/guardians, doctor, staff, or teachers associated with their activity including any signs and symptoms of HEAT-RELATED ILLNESS. My child and I have read and understood the above information on heat-related illnesses. My child/ward will inform the supervising teacher, staff, or parent immediately if they experience any of these symptoms or witness another student with these symptoms. Furthermore, I have been advised of the dangers of participation for my child.

_____	_____	____/____/_____
Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date

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Consent and Release from Liability Certificate

Part 1. Student Acknowledgement and Release

I have read the FSMA Rules and Regulations pertaining to eligibility (available at www.flmusiced.org under FSMA Rules and Regulations) and know of no reason why I am not eligible to participate in music performance assessments, or extracurricular or co-curricular music activities (e.g., marching band, color guard, drum line, etc.). I agree to follow the rules of my school district policies viewable at www.collierschools.com . I know of the risks involved in participation, understand that injury, including the potential for a concussion or heat-related illness, is possible in such participation, and choose to accept such risks. I voluntarily accept any and all responsibility for my own safety and welfare while participating in these activities, with full understanding of the risks involved. Should I be 18 years of age or older, or should I be emancipated from my parent(s)/guardian(s), I hereby release and hold harmless my school, the schools at which I perform, the school district, the adjudicators of the sanctioned event of any and all responsibility and liability for any injury or claim resulting from such participation and agree to take no legal action against CCPS because of any accident or mishap involving my participation. I hereby authorize the use or disclosure of my individually identifiable health information should treatment for illness or injury become necessary. I hereby grant to CCPS the right to review all records relevant to my eligibility including, but not limited to, my records relating to enrollment and attendance, age, discipline, finances, residence, and physical fitness. The released parties, however, are under no obligation to exercise said rights herein. I understand that the authorizations and rights granted herein are voluntary and that I may revoke any or all of them at any time by submitting said revocation in writing to my school.

Part 2. Parental/Guardian Consent, Acknowledgement and Release

I understand that participation may necessitate an early dismissal from classes. I know of, and acknowledge that my child/ward knows of, the risks involved in participation, understand that injury is possible in such participation and choose to accept any and all responsibility for their safety and welfare while participating in these activates. With full understanding of the risks involved, I release and hold harmless my child's/ward's school, the schools at which they perform, the school district, the adjudicators and FSMA of any and all responsibility and liability for any injury or claim resulting from such participation and agree to take no legal action against the FSMA because of any accident or mishap involving the participation of my child/ward.

I authorize emergency medical treatment for my child/ward should the need arise for such treatment while my child/ward is under the supervision of the school.

I further hereby authorize the use or disclosure of my child's/ward's individually identifiable health information should treatment for illness or injury become necessary. I consent to the disclosure, by my child's/ward's school, to CCPS, upon its request, of all records relevant to their athletic eligibility including, but not limited to, their records relating to enrollment and attendance, age, discipline, finances, residence and physical fitness.

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The released parties, however, are under no obligation to exercise said rights herein. I am aware of the potential danger of concussions, head and neck injuries, and/or heat related illness.

I also have knowledge about the risk of continuing to participate once such an injury is sustained without proper medical clearance.

I agree that in the event we/I pursue litigation seeking injunctive relief or other legal action impacting my child/ward's participation in FSMA sanctioned events, such action shall be filed in Leon County, Florida.

I understand that the authorizations and rights granted herein are voluntary and that I may revoke any or all of them at any time by submitting said revocation in writing to my child/ward's school.

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE

_____	_____	____/____/_____
Name of Parent/Guardian (printed)	Signature of Parent/Guardian	Date

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Participant Physical Evaluation

Part 1. Student Information

Student's Name: _____ Sex: ____ Age: ____

Date of Birth: _____/_____/_____

School: _____ Grade in School: _____

Home Address: _____

Home Phone: (_____)_____

Name of Parent/Guardian: _____

Parent/Guardian E-mail: _____

Person to Contact in Case of Emergency: _____

Relationship: _____ Home Phone: (_____) _____

Work Phone: (_____) _____ Cell Phone: (_____) _____

Personal/Family Physician: _____

City/State: _____ Phone: (_____) _____

Part 2. Medical History

To be completed by parent/guardian or student. Please Circle Yes (Y) or No (N) "YES" answers should be explained.

Have you been diagnosed with a new medical condition since your last check up or physical? **Y or N**

If yes, please explain: _____

Do you have an ongoing chronic illness or medical condition? **Y or N** If so, please list:

_____

Have you ever had surgery? **Y or N**

If yes, please explain: _____

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Are you currently taking any prescription or non-prescription (over-the-counter) medications or using an inhaler? **Y or N**

If yes, please explain: _____

6. Do you have any allergies (for example, pollen, latex, medicine, food or stinging insects)? **Y or N**

List: _____

If so, do you require an epi-pen or emergency medication? **Y or N**

Do you have seasonal allergies that require medical treatment or restrictions? **Y or N**

Have you ever had a rash or hives develop during or after exercise? **Y or N**

Have you ever become dizzy or passed out during or after exercise? **Y or N**

Have you ever been dizzy during or after exercise? **Y or N**

Have you ever had racing of your heart or skipped heartbeats? **Y or N**

Have you ever been told you have a heart murmur? **Y or N**

Has a physician ever denied or restricted your activity levels for any reason? **Y or N**

Have you ever had a head injury or concussion? **Y or N**

Have you ever had numbness or tingling in your arms, hands, legs or feet? **Y or N**

Have you ever become ill from exercising in the heat? **Y or N**

Do you use any special protective or corrective equipment or medical devices (for example, knee brace, special neck roll, foot orthotics, shunt, retainer on your teeth or hearing aid)? **Y or N**

Have you had any problems with your eyes or vision? **Y or N**

Do you wear glasses, contacts or protective eyewear? **Y or N**

Have you had any other problems with pain or swelling in muscles, tendons, bones or joints? **Y or N**

If yes, check appropriate blank and explain below: Head ___ Elbow ___ Hip ___ Neck ___ Forearm ___ Thigh ___ Back ___ Wrist ___ Knee ___ Chest ___ Hand ___ Shin/Calf ___ Shoulder ___ Finger ___ Ankle ___ Upper Arm ___ Foot ___

If student is required to take medication during afterschool activities please complete attached Collier County Public Schools Medication Authorization Form and return to Activities Director.

We hereby state, to the best of our knowledge, that our answers to the above questions are complete and correct. In addition to the routine medical evaluation required by s.1006.20, Florida Statutes, and FHSAA Bylaw 9.7, we understand and acknowledge that we are hereby advised that the student should undergo a cardiovascular assessment, which may include such diagnostic tests as electrocardiogram (EKG), echocardiogram (ECG) and/or cardio stress test.

Signature of Parent/Guardian: _____ Date: ____/____/____

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Part 3. Physical Examination

(to be completed by licensed physician, physician assistant or certified advanced registered nurse practitioner).

Student's Name: _____ Date of Birth: _____/_____/_____

Height: _____ Weight: _____ % Body Fat (optional): _____

Pulse: _____ Blood Pressure: ____ / ____ (____/____ , ____ /____) Temperature: _____

Hearing: right: P ____ F ___ Left: P ___ F ___ Visual Acuity: Right 20/_____ Left 20/____

Corrected: Yes / No Pupils: Equal _____ Unequal _____

FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
1. Appearance	_____	_____	_____
2. Eyes/Ears/Nose/Throat	_____	_____	_____
3. Lymph Nodes	_____	_____	_____
4. Heart	_____	_____	_____
5. Pulses	_____	_____	_____
6. Lungs	_____	_____	_____
7. Abdomen	_____	_____	_____
8. Skin	_____	_____	_____
MUSCULOSKELETAL			
10. Neck	_____	_____	_____
11. Back	_____	_____	_____
12. Shoulder/Arm	_____	_____	_____
13. Elbow/Forearm	_____	_____	_____

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FINDINGS	NORMAL	ABNORMAL FINDINGS	INITIALS
14. Wrist/Hand	_____	_____	_____
15. Hip/Thigh	_____	_____	_____
16. Knee	_____	_____	_____
17. Leg/Ankle	_____	_____	_____
18. Foot	_____	_____	_____

ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

____ Cleared without limitation

____ Disability: _____ Diagnosis: _____

_____

____ Precautions: _____

_____

____ Not cleared for: _____Reason:_____

_____

____ Cleared after completing evaluation/rehabilitation for:_____

____ Referred to _____ For: _____

_____

Recommendations: _____

_____

Name of Physician/Physician Assistant/Nurse Practitioner (print):_____

Date: _____/_____/_____ Address: _____

Signature of Physician/Physician Assistant/Nurse Practitioner:_____

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ASSESSMENT OF PHYSICIAN TO WHOM REFERRED (if applicable)

I hereby certify that the examination(s) for which referred was/were performed by myself or an individual under my direct supervision with the following conclusion(s):

____ Cleared without limitation

____ Disability: _____ Diagnosis: _____

_____

____ Precautions: _____

_____

____ Not cleared for: _____ Reason:_____

_____

____ Cleared after completing evaluation/rehabilitation for:_____

____ Referred to _____ For:_____

_____

Recommendations:

_____

_____

Name of Physician/Physician Assistant/Nurse Practitioner (print):_____

Date: _____/_____/_____ Address:_____

Phone: _____ Fax: _____

Signature of Physician/Physician Assistant/Nurse Practitioner: _____

Place Healthcare Provider Stamp Here: