2020-2021
DIAA ATHLETIC PHYSICAL AND CONSENT FORMS

Upon publication of this packet, these forms MUST be utilized when completing required DIAA forms for the 2020-21 athletic season. Each year, the DIAA will utilize this cover letter to update providers on any important changes and important dates.

The DIAA Sports Medicine Advisory Committee recommends that the required forms be completed by the student athlete’s primary care provider (medical home) to ensure continuity of medical care. These forms must be completed after April 1st 2020 based on a physical performed by the signing physician within one year of the date of signature.

Please check the DIAA website for updates regarding COVID-19 and management of student athletes. As information is changing rapidly, DIAA, in collaboration with Division of Public Health (DPH) will post updates as needed to the website.

Key Changes for 2020-2021:

- This packet has been updated based upon new guidelines by the American Academy of Pediatrics Pre-Participation Evaluation (PPE) 5th Edition.

- There is now a checkbox on page 2 for immunizations that should be checked indicating that immunizations are attached when appropriate.

- Students who have not had a DIAA PPE such as students entering middle school, students who are first time participants in athletics, and out-of-state transfers, ARE required to have a PPE prior to athletic participation. All students entering sixth and ninth grade ARE required to have a PPE prior to athletic participation. Therefore, parents and guardians must complete and submit pages 2, 3 and 5, including a physician’s examination (page 4), prior to any participation.

- Due to the COVID-19 pandemic and concerns regarding access, returning student-athletes that had a valid 2019-2020 pre-participation physical may not be required to have a PPE until the end of the fall season and prior to starting the winter season. This means a physical that was good for the 2019-2020 season will be good for the start of the 2020-2021 season.

- However, a Supplemental Form [a new History Form * (page 3) and medical card * (page 5)], MUST be completed for all athletes, and based on review of the forms, the school’s qualified healthcare provider (QHP) will determine if a physical and evaluation by the student’s primary care provider is required prior to participation. For returning athletes, when completing the history form, please make sure to only answer “yes” if there are new issues since you were last cleared for participation/ last year’s valid PPE.

- Given the delay in publication of these forms, it is okay to submit the 2019-2020 packet (if signed by the physician before publication of the 2020-2021 forms) but the student athlete must submit an updated History Form (page 3) to be reviewed by the school’s QHP.

- All student-athletes will be screened for COVID-19 with a symptom checklist and temperature check daily prior to participation. If positive, athlete will be sent home by the school. The student-athlete will then need to be evaluated and cleared with a negative PCR test.
Delaware Interscholastic Athletic Association
Pre-Participation Physical Evaluation/Consent Form

The DIAA pre-participation physical evaluation and consent form consists of seven pages. Pages two, three and five require a parent's signature while pages six and seven are references for the parent and student athlete to keep. Page four requires the exam date and physician's signature and page five requires the clearance to participate date and physician’s signature. The student must be cleared to participate on or after April 1 based on a physical examination conducted within 12 months of the signature. The clearance is valid through June 30 of the following school year unless a re-examination is required.

Name of Athlete: ___________________________ School: ___________________________
Grade: _______ Age: _______ Gender: _______ Date of Birth: _______ Phone: _______
Parent/Guardian Name: (Please Print): __________________________________________

For the physicals of 9th graders or new school enterers, please check here indicating immunization form attached: ☐

PARENT/GUARDIAN/STUDENT CONSENTS
__________________________________________ has my permission to participate in all interscholastic sports NOT checked below?

(Note of Athlete)

NOTE- If you check any sport below the athlete will NOT be permitted to participate in that sport.

- Baseball - Basketball - Cheerleading - Cross Country - Crew
- Field Hockey - Football - Golf - Ice Hockey - Lacrosse (B)
- Lacrosse (G) - Soccer - Softball - Squash - Swimming
- Tennis - Track - Volleyball - Wrestling

1. My permission extends to all interscholastic activities whether conducted on or off school premises. I have read and discussed the Parent/Player Concussion Information Document; Sudden Cardiac Arrest Awareness Sheet and I will retain those pages for my reference. I have also discussed with him/her and we understand that physical injury, including paralysis, coma or death and exposure to COVID-19 can occur as a result of participation in interscholastic athletics. I waive any claim for injury, illness, or damage incurred by said participant while participating in the activities NOT checked above.

#1 Parent Signature: ___________________________ Date: ___________________________
#2 Student Signature: ___________________________ Date: ___________________________

2. To enable DIAA and its full and associate member schools to determine whether herein named student is eligible to participate in interscholastic athletics, I hereby consent to the release of any and all portions of school record files, beginning with the sixth grade, of the herein named student, including but not limited to, birth and age records, name and residence of student’s parent(s), guardian(s) or Relative Care Giver, residence of student, health records, academic work completed, grades received and attendance records.

#3 Parent Signature: ___________________________ Date: ___________________________

3. I further consent to DIAA and it’s full and associate member schools use of the herein named student’s name, likeness, and athletically related information in reports of interscholastic practices, scrimmages or contests, promotional literature of the association, and other materials and releases related to interscholastic athletics.

#4 Parent Signature: ___________________________ Date: ___________________________

4. By this signature, I hereby consent to allow the physician(s) and other health care provider(s) selected by myself or the schools to perform a pre-participation examination on my child and to provide treatment for any injury received while participating in or training for athletics for his/her school. I further consent to allow said physician(s) or health care provider(s) to share appropriate information concerning my child that is relevant to participation, with coaches, medical staff, Delaware Interscholastic Athletic Association, and other school personnel as deemed necessary. Such information may be used for injury surveillance purposes.

#5 Parent Signature: ___________________________ Date: ___________________________

5. By this signature, I agree to notify the physician and school of any health changes during the school year that could impact participation in interscholastic athletics.

#6 Parent Signature: ___________________________ Date: ___________________________
HISTORY FORM

*Form completed annually along with a Consent & Medical Card. Athlete and parent should fill out form prior to visit.

Name: ____________________________ Age: ____________________________ Date of Birth: ____________________________ Grade: ____________________________

Sex assigned at birth (F, M, or Intersex) _____ How do you identify your gender? (F, M, Other) _____ School: ____________________________ Sport(s): ____________________________

List past and current medical conditions: Have you ever had surgery? If yes list all past surgical procedures:

List all current prescriptions, otc medicines, and supplements (herbal & nutritional): List all of your allergies (medicines, pollens, food, stinging insects etc):

Over the past 2 weeks, how often have you been bothered by any of the following (circle)

- Feeling nervous, anxious, or on edge
- Not being able to stop or control worrying
- Little interest or pleasure in doing things
- Feeling down, depressed or hopeless

Mental Health: A sum of >= 3 for questions 1+2, or 3+4, is considered positive

* See repeat responders versus first responders

GENERAL QUESTIONS

1. Do you have any concerns you would like to discuss with your provider? Yes No

2. Has a provider ever denied or restricted your participation in sports for any reason? Yes No

3. Do you have any medical issues or recent illness? Yes No

HEART HEALTH QUESTIONS ABOUT YOU:

4. Have you ever passed out or nearly passed out during or after exercise? Yes No

5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? Yes No

6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? Yes No

7. Has a doctor told you that you have any heart issues? Yes No

8. Has a doctor ever requested a test for your heart? For example, electrocardiogram (EKG) or echocardiogram? Yes No

9. Do you get light headed or feel short of breath more than your friends during exercise? Yes No

10. Have you ever had a seizure? Yes No

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

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)? Yes No

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)? Yes No

13. Has anyone in your family had a pacemaker, or implanted defibrillator before age 35? Yes No

BONE AND JOINT QUESTIONS

14. Since you were last cleared to play sports, have you had a new injury to a bone, muscle, ligament or tendon? Yes No

MEDICAL QUESTIONS

15. Have you been diagnosed with COVID-19? Yes No

16. Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes No

17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? Yes No

18. Do you have groin or, testicle pain or a painful bulge or herna in the groin area? Yes No

19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)? Yes No

20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? Yes No

21. Have you ever had numbness, tingling, weakness in your arms or leg or been unable to move your arms or legs after being hit or falling? Yes No

22. Have you ever become ill during exercising in the heat? Yes No

23. Do you or someone in your family have sickle cell trait or disease? Yes No

24. Have you ever had or do you have problems with your eyes or vision? Yes No

25. Do you worry much about your weight? Yes No

26. Are you trying or has anyone recommended you gain or lose weight? Yes No

27. Are you on a special diet or do you avoid certain types of foods or food groups? Yes No

28. Have you ever had an eating disorder? Yes No

FEMALES ONLY

29. Have you ever had a menstrual period? Yes No

30. How old were you when you had your first menstrual period? Yes No

31. When was your most recent menstrual period? Yes No

32. How many periods have you had in the last 12 months? Yes No

Circle questions you do not know the answer to.* When answering questions, if you are a repeat responder (submitted PPE prior) only answer "Yes" if it is something new that has occurred since you were last cleared for athletic participation. If this is first time, answer "Yes" if ever occurred. Explain "yes" answers here:

SCHOOL QUALIFIED HEALTHCARE PROVIDER - (RN/AT)

If "yes" is answered to any of the above, or "3+" for mental health questions, since the athlete was last cleared for athletic participation, a referral and clearance by the athlete's primary care provider is required.

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

Signature of Athlete: ____________________________ Date: ____________________________

Signature Parent/Guardian: ____________________________ Date: ____________________________

Signature of School QHP: ____________________________ Date: ____________________________
PHYSICAL EXAMINATION FORM

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, 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)

<table>
<thead>
<tr>
<th>EXAMINATION</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BP</td>
<td>( )</td>
<td>( )</td>
<td>( )</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision R 20/</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision L 20/</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrected</td>
<td></td>
<td>Y</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEDICAL**

- Appearance
  - Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse MVP, aortic insufficiency)

- Eyes/ears/nose/throat
  - Pupil equal
  - Hearing

- Lymph nodes

- Heart
  - Murmurs (auscultation standing, supine, +/- Valsalva)

- Lungs

- Abdomen

- Skin
  - Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis

- Neurological

**MUSCULOSKELETAL**

- 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

*Consider ECG, echocardiogram, echocardiography, referral to cardiologist for abnormal cardiac history or examination findings, or a combination of these.

HEALTHCARE PROFESSIONAL: THIS FORM must be used in conjunction with MEDICAL HISTORY FORM [2] and MEDICAL CARD [4]. THIS FORM AND MEDICAL CARD MUST BE SIGNED BY MD/DO/NP/PA

Comments:

Name of Healthcare Professional (MD/DO/NP/PA) print or type: ________________________________ Date of Exam: ________________________________

Address: ________________________________

Phone: ________________________________

Signature of Healthcare Professional: ________________________________

Please sign pages four and five of the pre-participation packet

SCHOOL ATHLETE MEDICAL CARD *
(Parent/Guardian: Please complete Sections 1, 2 & 3. Please print.)

**Section 1: Contact / Personal Information**

Name: ________________________ Sport(s): ________________________
Age: _______ Birthdate: _______ School: ________________________ Grade: _______
Guardian Name: ________________________
Address: ________________________
Phone: (H) _______ (W): _______ (C): _______ (P) _______

Other Authorized Person To Contact In Case Of Emergency:
Name: ________________________ Phone(s): ________________________
Name: ________________________ Phone(s): ________________________

Preference Of Physician (And Permission To Contact If Needed):
Name: ________________________ Phone: ________________________
Hospital Preference: ________________________ Insurance: ________________________
Policy #: ________________________ Group: ________________________ Phone: ________________________

**Section 2: Medical Information**

Medical Illnesses: ________________________
Last Tetanus (Mo/Yr): _______ Allergies: ________________________ Braces/Splints: ________________________
Medications: ________________________

*(Any medication(s) that may need to be taken during competition require a physician’s note.)*

Previous Head/Neck/Back Injury: ________________________
Heat Disorder, Or Sickle Cell Trait: ________________________
Previous Significant Injuries: ________________________

Any Other Important Medical Information: ________________________

**Section 3: Consent for Athletic Conditioning, Training and Health Care Procedures**

I hereby give consent for my child to participate in the school’s athletic conditioning and training program, and to receive any necessary healthcare treatment including first aid, diagnostic procedures, and medical treatment, that may be provided by the treating physicians, nurses, athletic trainers, or other healthcare providers employed directly or through a contract by the school, or the opposing team’s school. The healthcare providers have my permission to release my child’s medical information to other healthcare practitioners and school officials. In the event I cannot be reached in an emergency I give permission for my child to be transported to receive necessary treatment. I understand that Delaware Interscholastic Athletic Association or its associates may request information regarding the athlete’s health status, and I hereby give my permission for the release of this information as long as the information does not personally identify my child.

**Parent/Guardian Signature:** ________________________ **Date:** ________________________

**Athlete’s Signature:** ________________________ **Date:** ________________________

**Section 4: Clearance for Participation**

____ Not Cleared ______ Cleared without restrictions ______ Cleared with the following restrictions: ________________________

**Health Care Provider’s Signature:** ________________________ **MD/DO, PA, NP Date:** ________________________

If this form is being completed as part of the supplemental form, then a physician signature is not needed until a new physical is performed.

For School Office Use Only: This card is valid from April 1, 20 ______ through June 30, 20 ______

Note: If any changes occur, a new card should be completed by the parent/guardian. The original card should be kept on file in the school nurse, athletic director’s or athletic trainer’s office. A copy should be kept in the sports’ athletic kit. This card contains personal medical information and should be treated as confidential by the school, its employees, agents, and contractors.

Name of School: ________________________ Name of School QHP: ________________________