

NORTH BRANFORD PUBLIC SCHOOLS

North Branford Intermediate School

Sport Activity Fee

All middle school students in the North Branford Public School system who wish to participate in any interscholastic athletic program must submit a mandatory sport activity fee of \$50 per sport. This fee must be submitted to the main office prior to the first date of practice for each respective sport. In the event that this fee has not been received, then the student-athlete will not be allowed to participate. Payment may be made by cash or check (made payable to "NBIS Athletics." All payments should be submitted in a sealed envelope with the student's name and sport on the envelope. The sport activity fee will be refunded should the student-athlete sustain a season-ending injury. A full refund will be issued if the injury is sustained prior to the first contest and will be prorated if the injury occurs after the first contest. The activity fee will also be refunded in the event that the student-athlete tries out but does not "make" the team due to unfortunate, yet necessary cuts. This situation may arise if more students try out than can feasibly or safely be accommodated for a particular sport.

Fee Schedule

\$50 per player per sport

\$300 cap per family (including high school athletes)

Fee Waiver

Student-athletes may have the fee waived if they qualify for free/reduced lunch. In this event, the school office will confirm with the Athletic Director prior to the onset of the season or date of the first competition.

Use of Fees

All collected fees will be used for equipment, coaching stipends, CIAC fees, transportation, and officials. This fee is being implemented solely due to budgetary constraints.

Playing Time

The participation fee is not connected to playing time. As in the past, participants' playing time is determined by the head coach and based upon the needs of the collective program.



North Branford Intermediate School

Sports Participation Fee Waiver Request Form

NBIS students who qualify for the Free and Reduced Lunch Program may apply to have their sports participation fee (\$50 per sport) waived. Information from Appendix A of your completed *Free and Reduced-price School Meals/ Milk Application* will be used to make the final determination regarding eligibility. This completed form should be submitted to the NBIS Office.

Applicant Information

Student's Name: _____

Parent/ Guardian: _____
Last First M.I.

Comments (optional):

Parent/ Guardian Signature

Date

Agreement

Waiver is not approved until signed by the NBIS Athletic Director, administrator, or designee. All athletes must comply with all of the NBIS athletic regulations, as detailed in our Student Handbook.

Office Use Only

Waiver approved: Yes _____ No _____

Athletic Director/ Administrator

Date

Date of Physical		NORTH BRANFORD PUBLIC SCHOOLS	Grade	
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PARENT'S PERMISSION FORM FOR ATHLETICS
20__ - 20__ SCHOOL YEAR

Athlete's Name: _____ Phone: _____
 Parent's Name: _____ Phone: _____
 Parent's Work Phone: () _____ or () _____

List the sports (Football, Soccer, VB, X-C, BB, etc.) that you are giving
 Permission for you child to participate in: **Do NOT just put an "X"**

Fall: _____ Winter: _____ Spring: _____

LIST any conditions that a coach should be aware of: _____

Date of last TETANUS Shot: _____

IN CASE OF EMERGENCY, Please contact one of the people listed below if a
 parent cannot be contacted/notified. **ALL** of the phone numbers listed below must
 be filled in **BEFORE** your child will be allowed to try-out or practice for a team.

Name: _____ Phone: _____ Relation: _____
 Name: _____ Phone: _____ Relation: _____

Hospital Preference : _____ Phone: _____
 Physician's Name: _____ Phone: _____
 Dentist's Name: _____ Phone: _____

I/We give permission for _____ (athlete's name) to participate in
 organized high school athletics for the current school year, realizing that such activity involves
 the potential for injury which is inherent in all sports. I/We acknowledge that even with the best
 coaching, use of the most advanced protective equipment and strict observance of rules, injuries
 can be so severe as to result in total disability, paralysis, or even death.

In case of emergency and I/We cannot be contacted, I/We give my/our permission
 for my/our child to receive medical attention.

Signature of Parent/Guardian: _____ Date: _____

(A xerox copy of this form will be carried by each coach to practice/contests)



State of Connecticut Department of Education Health Assessment Record



To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)		Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, Town and ZIP code)			
Parent/Guardian Name (Last, First, Middle)		Home Phone	Cell Phone
School/Grade	Race/Ethnicity <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other		
Primary Care Provider			
Health Insurance Company/Number* or Medicaid/Number*			
Does your child have health insurance? Y N		If your child does not have health insurance, call 1-877-CT-HUSKY	
Does your child have dental insurance? Y N			

* If applicable

Part I — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle Y if "yes" or N if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y N	Hospitalization or Emergency Room visit	Y N	Concussion	Y N
Allergies to food or bee stings	Y N	Any broken bones or dislocations	Y N	Fainting or blacking out	Y N
Allergies to medication	Y N	Any muscle or joint injuries	Y N	Chest pain	Y N
Any other allergies	Y N	Any neck or back injuries	Y N	Heart problems	Y N
Any daily medications	Y N	Problems running	Y N	High blood pressure	Y N
Any problems with vision	Y N	"Mono" (past 1 year)	Y N	Bleeding more than expected	Y N
Uses contacts or glasses	Y N	Has only 1 kidney or testicle	Y N	Problems breathing or coughing	Y N
Any problems hearing	Y N	Excessive weight gain/loss	Y N	Any smoking	Y N
Any problems with speech	Y N	Dental braces, caps, or bridges	Y N	Asthma treatment (past 3 years)	Y N
Family History				Seizure treatment (past 2 years)	Y N
Any relative ever have a sudden unexplained death (less than 50 years old)			Y N	Diabetes	Y N
Any immediate family members have high cholesterol			Y N	ADHD/ADD	Y N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any medications your child will need to take in school:

All medications taken in school require a separate Medication Authorization Form signed by a health care provider and parent/guardian.

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian

Date

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

*Height _____ in. / _____ % *Weight _____ lbs. / _____ % BMI _____ / _____ % Pulse _____ *Blood Pressure _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen			*Postural <input type="checkbox"/> No spinal abnormality <input type="checkbox"/> Spine abnormality: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Referral made		
Genitalia/ hernia					
Skin					

Screenings

*Vision Screening			*Auditory Screening			Lead:	Date
Type:	Right	Left	Type:	Right	Left		
With glasses	20/	20/		<input type="checkbox"/> Pass	<input type="checkbox"/> Pass	*HCT/HGB:	
Without glasses	20/	20/		<input type="checkbox"/> Fail	<input type="checkbox"/> Fail		
<input type="checkbox"/> Referral made			<input type="checkbox"/> Referral made			Other:	
TB: High-risk group?		<input type="checkbox"/> No <input type="checkbox"/> Yes	PPD date read:		Results:	Treatment:	

***IMMUNIZATIONS**

Up to Date or Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

- Asthma No Yes: Intermittent Mild Persistent Moderate Persistent Severe Persistent Exercise induced
If yes, please provide a copy of the Asthma Action Plan to School
- Anaphylaxis No Yes: Food Insects Latex Unknown source
Allergies If yes, please provide a copy of the Emergency Allergy Plan to School
History of Anaphylaxis No Yes Epi Pen required No Yes
- Diabetes No Yes: Type I Type II Other Chronic Disease: _____
- Seizures No Yes, type: _____

This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: _____

Daily Medications (specify): _____

This student may: participate fully in the school program
 participate in the school program with the following restriction/adaptation: _____

This student may: participate fully in athletic activities and competitive sports
 participate in athletic activities and competitive sports with the following restriction/adaptation: _____

Yes No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? Yes No I would like to discuss information in this report with the school nurse.

Signature of health care provider MD/DO/APRN/PA

Date Signed

Printed/Stamped Provider Name and Phone Number

Student and Parent Concussion Informed Consent Form

This consent form was developed to provide students and parents with current and relevant information regarding concussions and to comply with Connecticut General Statutes (C.G.S.) Chapter 163, Section 149b: *Concussions: Training courses for coaches. Education plan. Informed consent form. Development or approval by the State Board of Education* and Section 10-149c: *Student athletes and concussions. Removal from athletic activities. Notification of parent or legal guardian. Revocation of coaching permit.*

What is a Concussion?

National Athletic Trainers Association (NATA) - *A concussion is a "trauma induced alteration in mental status that may or may not involve loss of consciousness."*

Centers for Disease Control and Prevention (CDC) - *"A concussion is a type of traumatic brain injury, or TBI, caused by a bump, blow, or jolt to the head that can change the way your brain normally works. Concussions can also occur from a blow to the body that causes the head to move rapidly back and forth."* -CDC, Heads Up: Concussion

http://www.cdc.gov/headsup/basics/concussion_whatIs.html

Even a "ding," "getting your bell rung," or what seems to be mild bump or blow to the head can be serious" -CDC, Heads Up: Concussion Fact Sheet for Coaches http://www.cdc.gov/concussion/HeadsUp/pdf/Fact_Sheet_Coaches-a.pdf

Section 1. Concussion Education Plan Summary

The Concussion Education Plan and Guidelines for Connecticut Schools was approved by the Connecticut State Board of Education in January 2015. Below is an outline of the requirements of the Plan. The complete document is accessible on the CSDE Web site: <http://www.sde.ct.gov/sde/cwp/view.asp?a=2663&q=335572>

State law requires that each local and regional board of education must approve and then implement a concussion education plan by using written materials, online training or videos, or in-person training that addresses, at a minimum the following:

1. The recognition of signs or symptoms of concussion.
2. The means of obtaining proper medical treatment for a person suspected of sustaining a concussion.
3. The nature and risks of concussions, including the danger of continuing to engage in athletic activity after sustaining a concussion.
4. The proper procedures for allowing a student athlete who has sustained a concussion to return to athletic activity.
5. Current best practices in the prevention and treatment of a concussion.

Section 2. Signs and Symptoms of a Concussion: Overview

A concussion should be suspected if any one or more of the following signs or symptoms are present, or if the coach/evaluator is unsure, following an impact or suspected impact as described in the CDC definition above.

Signs of a concussion may include (i.e. what the athlete displays/looks like to an observer):

- Confusion/disorientation/irritability
- Trouble resting/getting comfortable
- Lack of concentration
- Slow response/drowsiness
- Incoherent/ slurred speech
- Slow/clumsy movements
- Loses consciousness
- Amnesia/memory problems
- Acts silly/combative/aggressive
- Repeatedly ask same questions
- Dazed appearance
- Restless/Irritable
- Constant attempts to return to play
- Constant motion
- Disproportionate/inappropriate reactions
- Balance problems

Symptoms of a concussion may include (i.e. what the athlete reports):

- Headache or dizziness
- Nausea or vomiting
- Blurred or double vision
- Oversensitivity to sound/light/touch
- Ringing in ears
- Feeling foggy or groggy

State law requires that a coach MUST immediately remove a student-athlete from participating in any intramural or interscholastic athletic activity who: a) is observed to exhibit signs, symptoms or behaviors consistent with a concussion following a suspected blow to the head or body, or b) is diagnosed with a concussion, regardless of when such concussion or head injury may have occurred. Upon removal of the athlete, a qualified school employee must notify the parent or legal guardian within 24 hours that the student athlete has exhibited signs and symptoms of a concussion.

Section 3. Return to Play (RTP) Protocol Overview

Currently, it is impossible to accurately predict how long an individual's concussion will last. There must be full recovery before a student-athlete is allowed to resume participating in athletic activity. Connecticut law now requires that no athlete may resume participation until they have received written medical clearance from a licensed health care professional (physician, physician assistant, advanced practice registered nurse (APRN), athletic trainer) trained in the evaluation and management of concussions.

Concussion Management Requirements:

1. No athlete SHALL return to participation in the athletic activity on the same day of concussion.
2. If there is any loss of consciousness, vomiting or seizures, the athlete MUST be immediately transported to the hospital.
3. Close observation of an athlete MUST continue following a concussion. The athlete should be monitored for an appropriate amount of time following the injury to ensure that there is no worsening/escalation of symptoms.
4. Any athlete with signs or symptoms related to a concussion MUST be evaluated by a licensed health care professional (physician, physician assistant, advanced practice registered nurse (APRN), athletic trainer) trained in the evaluation and management of concussions.
5. The athlete MUST obtain an initial written clearance from one of the licensed health care professionals identified above directing her/him into a well-defined RTP stepped protocol similar to the one outlined below. If at any time signs or symptoms return during the RTP progression, the athlete should cease activity.
6. After the RTP protocol has been successfully administered (no longer exhibits any signs or symptoms or behaviors consistent with concussions), final written medical clearance is required by one of the licensed health care professionals identified above for the athlete to fully return to unrestricted participation in practices and competitions.

Medical Clearance RTP protocol (Recommended one full day between steps)

Rehabilitation stage	Functional exercise at each stage of rehabilitation	Objective of each stage
1. No activity	Complete physical and cognitive rest until asymptomatic. School may need to be modified.	Recovery
2. Light aerobic exercise	Walking, swimming or stationary cycling maintaining intensity, <70% of maximal exertion; no resistance training	Increase Heart Rate
3. Sport specific exercise No contact	Skating drills in ice hockey, running drills in soccer; no head impact activities	Add Movement
4. Non-contact sport drills	Progression to more complex training drills, i.e. passing drills in football and ice hockey; may start progressive resistance training	Exercise, coordination and cognitive load
5. Full contact sport drills	Following final medical clearance, participate in normal training activities	Restore confidence and assess functional skills by coaching staff
6. Full activity	No restrictions	Return to full athletic participation

If at any time signs or symptoms should worsen during the RTP progression the athlete should stop activity that day. If the athlete's symptoms are gone the next day, she/he may resume the RTP progression at the last step completed in which no symptoms were present. If symptoms return and don't resolve, the athlete should be referred back to her/his medical provider.

Section 4. Local/Regional Board of Education Policies Regarding Concussions

***** Attach local or regional board of education concussion policies *****

I have read and understand this document the "Student and Parent Concussion Informed Consent Form" and understand the severities associated with concussions and the need for immediate treatment of such injuries.

Student name: _____ Date _____ Signature _____
 (Print Name)

I authorize my child to participate in _____ for school year _____
 (Sport/Activity)

Parent/Guardian name: _____ Date _____ Signature _____
 (Print Name)

References:

1. NFHS. Concussions. 2008 NFHS Sports Medicine Handbook (Third Edition). 2008. 77-82. <http://www.nfhs.org>. http://journal11.iupui.com/clearances/Pdf/text/2008/05000/Consensus_Statement_on_Concussion_in_Sport_3rd_3.aspx.
2. Centers for Disease Control and Prevention. Heads Up: Concussion in High School Sports. http://www.cdc.gov/NCIPC/tbl/Coaches_Tool_Kit.htm.
3. CIAC Concussion Central - <http://concussioncentral.ciacsports.com/>

Resources:

- Centers for Disease Control and Prevention. Injury Prevention & Control: Traumatic Brain Injury. Retrieved on June 16, 2010. <http://www.cdc.gov/TraumaticBrainInjury/index.html>
- Centers for Disease Control and Prevention. Heads Up: Concussion in High School Sports Guide for Coaches. Retrieved on June 16, 2014.

School Name _____

**Sudden Cardiac Arrest
Student & Parent Informed Consent Form**

NOTE: This document was developed to provide student-athletes and parents/guardians with current and relevant information regarding sudden cardiac arrest. A new form is required to be read, signed, dated and kept on file by the student-athlete's associated school district annually to comply with Connecticut General Statutes Chapter 163, Section 10-149f: **SUDDEN CARDIAC ARREST AWARENESS EDUCATION PROGRAM.**

Part I – SUDDEN CARDIAC ARREST - What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens, blood stops flowing to the brain and other vital organs. SCA doesn't just happen to adults; it takes the lives of students, too. However, the causes of sudden cardiac arrest in students and adults can be different. A student's SCA will likely result from an inherited condition, while an adult's SCA may be caused by either inherited or lifestyle issues. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

PART II - HOW COMMON IS SUDDEN CARDIAC ARREST IN THE UNITED STATES?

SCA is the #1 cause of death for adults in this country. There are about 300,000 cardiac arrests outside hospitals each year. It is a leading cause of death for student athletes.

According to an April 2014 study for PubMed the incidence was

- 0.63 per 100,000 in all students (6 in one million)
- 1.14 per 100,000 athletes (10 in one million)
- 0.31 per student non-athletes (3 in one million)
- The relative risk of SCA in student athletes vs non-athletes was 0.65
- There is a significantly higher risk of SCA for boys than girls

Leading causes of sudden death among high school and college athletes, according to the NCAA (on CBS News, June 28, 2012)* are heat stroke, heart disease and traits associated with sickle cell anemia. Prevention of sudden death, the same study concludes, is associated with more advanced cardiac screening with attention to medical histories and birth records, improved emergency procedures, and good coaching and conditioning practices.

PART III - WHAT ARE THE WARNING SIGNS AND SYMPTOMS?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as: fainting or seizures during exercise; unexplained shortness of breath; dizziness; extreme fatigue; chest pains; or racing heart. These symptoms can be unclear in athletes, since people often confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

Sudden cardiac arrest is a medical emergency. If not treated immediately, it causes sudden cardiac death. With fast, appropriate medical care, survival is possible. Administering cardiopulmonary resuscitation (CPR) — or even just compressions to the chest — can improve the chances of survival until emergency personnel arrive.

(<http://www.mavoclinic.org/diseases-conditions/sudden-cardiac-arrest/basics/>)

WHAT ARE THE RISKS OF PRACTICING OR PLAYING AFTER EXPERIENCING THESE SYMPTOMS?

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who experience SCA die from it.

REMOVAL FROM PLAY

Any student-athlete who shows signs or symptoms of SCA must be removed from athletic activity and referred to a licensed health care professional trained specifically in the treatment of cardiac care. The symptoms can happen before, during or after activity.

RETURN TO PLAY

Before returning to play, the athlete must be evaluated. Clearance to return to play must be in writing. The evaluation must be performed and written clearance be provided by a licensed medical provider.

To summarize:

- SCA is, by definition, sudden and unexpected.
- SCA can happen in individuals who appear healthy and have no known heart disease.
- Most people who have SCA die from it, usually within minutes.
- Rapid treatment of SCA with a defibrillator can be lifesaving.
- Training in recognition of signs of cardiac arrest and SCA, and the availability of AEDs and personnel who possess the skills to use one, may save the life of someone who has had an SCA.

(National Heart, Lung, and Blood Institute)

I have read and understand this document the "Student & Parent Informed Consent Form" and understand the severities associated with sudden cardiac arrest and the need for immediate treatment of any suspected condition.

Student name: _____ Date _____ Signature _____
(Print Name)

I authorize my child to participate in _____ for school year _____
(Sport/Activity)

Parent/Guardian name: _____ Date _____ Signature _____
(Print Name)

Sources:

Simons Fund - <http://www.simonsfund.org/>

Pennsylvania Department of Health - <http://www.simonsfund.org/wp-content/uploads/2012/06/Parent-Handout-SCA.pdf>