



### CHAPELGATE STUDENT-ATHLETE POLICY 2019-2020

As a student athlete, who is an ambassador for God and a representative of Chapelgate Christian Academy, I agree to adhere to the following guidelines in accordance with the philosophy set forth by Chapelgate Athletics.

- 1) I understand it is my responsibility to acquire and maintain academic eligibility. I may not use an athletic event as an excuse for late or missing class work.
- 2) Participation on a sports team involves commitment. This will be demonstrated by attending practice and games daily, arriving on time, putting my CCA team before other non CCA teams, arranging my work schedule around my CCA team commitments, etc... If I am chosen on a team, I understand that a lack of commitment to my team may result in less playing time and/or dismissal from the team.
- 3) As a representative of a CCA athletic team, I understand that I may be held accountable to uphold a high standard of character, work ethic, and commitment to grades and team. Therefore, I plan to:
  - exhibit honesty in words and play
  - submit to my coaches authority
  - follow and obey the transportation requirements set by CCA
  - demonstrate good sportsmanship
  - show respect to referees, opponents, teammates, coaches
  - refrain from any and all forms of initiation/hazing
  - be a good steward of uniforms, equipment, and buses
- 4) I understand that the following things are not permitted:
  - a. Inappropriate language
  - b. Fighting
  - c. Use of alcohol and/or drugs
  - d. Insubordination
  - e. Gossiping
- 5) I understand that it is my responsibility to have arrangement for a ride home at the dismissal time of practices or games. My lack in abiding by this may result in player consequences as well as possible forfeiture of my participation on the team.
- 6) If I have a late practice or game, I understand that I must be in the required study-hall or off campus until the practice or game begins.

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Student's Name Printed

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Student's Signature

**As the parent/guardian of the athlete named above, I confirm that I have read the athletic parent handbook and agree to uphold its policies and rules.**

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Printed Parent's Name

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Parent's Signature

**CHAPELGATE ATHLETIC ACCIDENT CARD 2019-2020**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Student Address: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I give permission for my child to obtain medical treatment if needed. Circle one: YES NO

List known allergies (ie- penicillin, bee stings, etc.): \_\_\_\_\_

List medical conditions & necessary devices (ie- epi-pen, inhaler, diabetic, heart murmur, etc):  
\_\_\_\_\_

Parent Name: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

**Please fill out both copies**

**CHAPELGATE ATHLETIC ACCIDENT CARD 2019-2020**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Student Address: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I give permission for my child to obtain medical treatment if needed. Circle one: YES NO

List known allergies (ie- penicillin, bee stings, etc.): \_\_\_\_\_

List medical conditions & necessary devices (ie- epi-pen, inhaler, diabetic, heart murmur, etc):  
\_\_\_\_\_

Parent Name: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

Chapelgate Christian Academy  
 Pre-Participation Physical Evaluation  
 For School Year 2019-2020  
**EXAM DATE MUST BE AFTER APRIL 1, 2019**

Name: \_\_\_\_\_ Circle one: Male Female Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Sport(s): \_\_\_\_\_

**In Case of Emergency, Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_ Policy# : \_\_\_\_\_ Group #: \_\_\_\_\_  
 Name of Insured: \_\_\_\_\_

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**To be completed by examining physician/nurse practitioner/physician assistant**

**Exam Date:** \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Eyes: R20/\_\_\_\_ L20/\_\_\_\_ Corrected? Y/N  
 Pupils: Equal/Unequal Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

MEDICAL EXAM	Normal	Abnormal Findings
Appearance		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Genitalia		
Skin		
MUSCULOSKELETAL EXAM	Normal	Abnormal Findings
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot		

**CLEARANCE**

Cleared

Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Not cleared for sports. Reason: \_\_\_\_\_

Other recommendation(s): \_\_\_\_\_

I certify that I have on this date examined the above student and have found no medical reason to disqualify him/her from participating in all supervised athletics and physical education activities with the exception of \_\_\_\_\_.

\_\_\_\_\_  
Name of Physician/CNP/PA

\_\_\_\_\_  
Signature of Physician/CNP/PA

**PHYSICIAN STAMP:**

**To be completed by student and parent/guardian:**

1. Have you had a medical illness or injury since your last exam? Do you have an ongoing or chronic illness?	Yes / No Yes / No
2. Have you ever had surgery? Yes / No	
3. Are you currently taking any prescription or non-prescription medication or using an inhaler?	Yes / No
4. Do you have any food or drug allergies? If yes, do you carry an epinephrine injector?	Yes / No Yes / No
5. Have you ever passed out or been dizzy during exercise? Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?	Yes / No Yes / No
Does your heart race or skip beats (irregular beats) during exercise?	Yes / No
Has a physician ever told you that you have heart problems? If so, circle all that apply: High Blood Pressure   High Cholesterol   A heart murmur   A heart infection   Kawasaki Disease   Other	Yes / No
Has a physician ever ordered a test for the heart?(i.e., ECG/EKG, echocardiogram)	Yes / No
Has a physician ever denied or restricted your sports participation because of heart problem?	Yes / No
Has a family member or relative died of heart problems or had an unexpected or unexplained sudden death before the age of 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?	Yes / No
Does anyone in your family have hypertrophic cardiomyopathy, Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada Syndrome, or catecholaminergic polymorphic ventricular tachycardia?	Yes / No
Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	Yes / No
6. Have you had a viral infection within the last month (i.e., mononucleosis)?	Yes / No
7. Have you had a bacterial infection within the last month (i.e., staphylococcus)?	Yes / No
8. Do you have any current skin problems (i.e., rash, fungus, hives)?	Yes / No
9. Have you had a herpes or MRSA skin infection?	Yes / No
10. Have you ever had a head injury or concussion? Have you ever been knocked out, become unconscious, or lost memory?	Yes / No Yes / No
Have you ever had a seizure?	Yes / No

Do you have frequent or severe headaches?	Yes / No
Have you ever had a "stinger", "burner", or pinched nerve?	Yes / No
11. Have you ever become ill from exercising in the heat?	Yes / No
12. Do you cough, wheeze, or have trouble breathing during exercise?	Yes / No
Do you have asthma?	Yes / No
Do you have seasonal allergies that require medical treatment?	Yes / No
13. Do you require special protective or corrective equipment that you use during exercise?	Yes / No
14. Do you wear glasses, contacts, or protective eyewear?	Yes / No
15. Have you ever had a sprain, strain, fracture, or dislocation?	Yes / No
16. Has a physician ever told you or a family member that you/they have sickle cell trait or sickle cell disease?	Yes / No
17. Record the dates of your most recent immunizations for: Tetanus _____ Hepatitis B _____ Measles _____ Chickenpox _____	
Females Only: 18. At what age was your first menstrual cycle? _____ When was your last menstrual cycle? _____ How many menstrual cycles do you have in a year? _____	

**Explain "YES" answers here and separate sheet as necessary:** \_\_\_\_\_

I give consent, in the event of illness or injury, for administration of reasonable and prudent first-aid, emergency or professional medical care. I hereby release, discharge, and waive all claims and causes of action against coaches, athletic directors, athletic trainers, and staff members of Chapelgate Christian Academy, as well as the school itself from any damages and injuries that might be incurred during any team practice, game, meeting, or during transportation to and from these activities. I acknowledge there are certain inherent risks associated with physical activity. I authorize the release of medical information to or between: (a) the Chapelgate Christian Academy Athletic Department Sports Medicine Staff (i.e., licensed athletic trainer, team physician, and consulting physician), (b) my child's physician/medical caregiver, (c) coaching staffs, and (d) school nurse and the administrative personnel of Chapelgate Christian Academy, concerning injuries or illnesses relating to my child's participation in athletics, past, present, or in the future. I acknowledge that my child and I have read and understand the information presented in the Concussion Information Sheet and the Cardiac Information Sheet. I acknowledge that if at any time we seek a physician's care, except for routine dental, vision, and gynecological visits, a note of clearance for sports participation must be returned before my child will be permitted to participate. I give permission for my child to participate in Chapelgate Christian Academy sponsored athletics. I certify that my child is in good health and know of no physical conditions, which by participation, would endanger my child's health.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Concussion INFORMATION SHEET



This sheet has information to help protect your children or teens from concussion or other serious brain injury. Use this information at your children's or teens' games and practices to learn how to spot a concussion and what to do if a concussion occurs.

## What Is a Concussion?

A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move quickly back and forth. This fast movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging the brain cells.

## How Can I Help Keep My Children or Teens Safe?

Sports are a great way for children and teens to stay healthy and can help them do well in school. To help lower your children's or teens' chances of getting a concussion or other serious brain injury, you should:

- Help create a culture of safety for the team.
  - Work with their coach to teach ways to lower the chances of getting a concussion.
  - Talk with your children or teens about concussion and ask if they have concerns about reporting a concussion. Talk with them about their concerns; emphasize the importance of reporting concussions and taking time to recover from one.
  - Ensure that they follow their coach's rules for safety and the rules of the sport.
  - Tell your children or teens that you expect them to practice good sportsmanship at all times.
- When appropriate for the sport or activity, teach your children or teens that they must wear a helmet to lower the chances of the most serious types of brain or head injury. However, there is no "concussion-proof" helmet. So, even with a helmet, it is important for children and teens to avoid hits to the head.



**Plan ahead.** What do you want your child or teen to know about concussion?

## How Can I Spot a Possible Concussion?

Children and teens who show or report one or more of the signs and symptoms listed below—or simply say they just "don't feel right" after a bump, blow, or jolt to the head or body—may have a concussion or other serious brain injury.

### Signs Observed by Parents or Coaches

- Appears dazed or stunned
- Forgets an instruction, is confused about an assignment or position, or is unsure of the game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events *prior to or after* a hit or fall

### Symptoms Reported by Children and Teens

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness, or double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Confusion, or concentration or memory problems
- Just not "feeling right," or "feeling down"

**Talk with your children and teens about concussion.** Tell them to report their concussion symptoms to you and their coach right away. Some children and teens think concussions aren't serious, or worry that if they report a concussion they will lose their position on the team or look weak. Be sure to remind them that *it's better to miss one game than the whole season.*



[cdc.gov/HEADSUP](https://cdc.gov/HEADSUP)

## CONCUSSIONS AFFECT EACH CHILD AND TEEN DIFFERENTLY.

While most children and teens with a concussion feel better within a couple of weeks, some will have symptoms for months or longer. Talk with your children's or teens' healthcare provider if their concussion symptoms do not go away, or if they get worse after they return to their regular activities.

### What Are Some More Serious Danger Signs to Look Out For?

In rare cases, a dangerous collection of blood (hematoma) may form on the brain after a bump, blow, or jolt to the head or body and can squeeze the brain against the skull. Call 9-1-1 or take your child or teen to the emergency department right away if, after a bump, blow, or jolt to the head or body, he or she has one or more of these danger signs:

- One pupil larger than the other
- Drowsiness or inability to wake up
- A headache that gets worse and does not go away
- Slurred speech, weakness, numbness, or decreased coordination
- Repeated vomiting or nausea, convulsions or seizures (shaking or twitching)
- Unusual behavior, increased confusion, restlessness, or agitation
- Loss of consciousness (passed out/knocked out). Even a brief loss of consciousness should be taken seriously

Children and teens who continue to play while having concussion symptoms, or who return to play too soon—while the brain is still healing—have a greater chance of getting another concussion. A repeat concussion that occurs while the brain is still healing from the first injury can be very serious, and can affect a child or teen for a lifetime. It can even be fatal.

### What Should I Do If My Child or Teen Has a Possible Concussion?

As a parent, if you think your child or teen may have a concussion, you should:

1. Remove your child or teen from play.
2. Keep your child or teen out of play the day of the injury. Your child or teen should be seen by a healthcare provider and only return to play with permission from a healthcare provider who is experienced in evaluating for concussion.
3. Ask your child's or teen's healthcare provider for written instructions on helping your child or teen return to school. You can give the instructions to your child's or teen's school nurse and teacher(s) and return-to-play instructions to the coach and/or athletic trainer.

Do not try to judge the severity of the injury yourself. Only a healthcare provider should assess a child or teen for a possible concussion. Concussion signs and symptoms often show up soon after the injury. But you may not know how serious the concussion is at first, and some symptoms may not show up for hours or days.

The brain needs time to heal after a concussion. A child's or teen's return to school and sports should be a gradual process that is carefully managed and monitored by a healthcare provider.

To learn more, go to [cdc.gov/HEADSUP](https://www.cdc.gov/HEADSUP)



## CHAPEL GATE CHRISTIAN ACADEMY Sudden Cardiac Arrest Information

Sudden cardiac arrest (SCA) is when the heart suddenly stops beating, resulting in no blood flow to the brain and other vital organs. Approximately 300,000 out-of-hospital cardiac arrests occur each year in the United States.

SCA happens without warning and requires emergency treatment. A person having SCA needs to be treated with a defibrillator right away. This device sends an electric shock to the heart. The electric shock can restore a normal rhythm to a heart that's stopped beating. To work well, defibrillation must be done within minutes of SCA. Rapidly implementing the "chain of survival" model can help increase the chances of survival from sudden cardiac arrest. With every minute that passes, the chances of surviving SCA drop rapidly.

The steps in the chain include activation of emergency medical services by calling 9-1-1 if someone has signs or symptoms of SCA, starting cardiopulmonary resuscitation (CPR), using an automated external defibrillator (AED), and acquiring appropriate care.

SCA should be suspected in any athlete who has collapsed and is unresponsive.

(6/2019)