CIF GRADED CONCUSSION SYMPTOM CHECKLIST

Today's Date: ____________  Time: ____________  Hours of Sleep: ____________  Date of Diagnosis: ____________

- Grade the 22 symptoms with a score of 0 through 6.
  - Note that these symptoms may not all be related to a concussion.
- You can fill this out at the beginning of the season as a baseline (after a good night's sleep).
- If you suffer a suspected concussion, use this checklist to record your symptoms daily.
  - Be consistent and try to grade either at the beginning or end of each day.
- There is no scale to compare your total score to; this checklist helps you follow your symptoms on a day-to-day basis.
  - If your total scores are not decreasing, see your physician right away.
- Show your baseline (if available) and daily checklists to your physician.

<table>
<thead>
<tr>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Pressure in head&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Neck Pain</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Nausea or Vomiting</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Dizziness</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Blurred Vision</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Balance Problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Sensitivity to light</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Sensitivity to noise</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Feeling slowed down</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Feeling like &quot;in a fog&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>&quot;Don't feel right!&quot;</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Difficulty concentrating</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Difficulty remembering</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Fatigue or low energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Confusion</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Drowsiness</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Trouble falling asleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>More emotional than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Irritability</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Sadness</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Nervous or Anxious</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

TOTAL SUM OF EACH COLUMN 0

TOTAL SYMPTOM SCORE (Sum of all column totals)

NAME ___________________________________________  HIGH SCHOOL ________________________________

D.O.B. ___________  SPORT ______________________  PHYSICIAN (MD/DO) ____________________________

CIFSTATE.ORG

CIF 5/2015
CRISTO REY HIGH SCHOOL
WAIVER AND RELEASE OF LIABILITY

In exchange for being allowed to participate in Cristo Rey High School Athletic Activities (hereafter “Event”), I agree, on behalf of myself and/or on behalf of my child, to be bound by the following:

Assumption of Risk
I______________________________, on behalf of myself and/or on behalf of my child, expressly acknowledge that participation in athletic activities and travel is completely voluntary, and I, on behalf of myself and/or on behalf of my child voluntarily accept personal responsibility for any liability, injury, loss, or damage in any way resulting from my and/or my child’s participation in the school activity and related transportation.

Identification of Risks
I understand that there are certain dangers, hazards, and risks inherent in travel and the activities included in the Event and transportation. I understand that such dangers, hazards, and risks may involve risk of injury and loss, both to person and to property. I further understand that the risk of injury may include the possibility of permanent disability and death. There may be other risks not known or not reasonably foreseeable at this time. I further understand that Cristo Rey High School does not assume responsibility for any such injuries or loss.

Waiver and Release
In consideration of participation in the Event, I waive and release Cristo Rey High School, its employees, agents, volunteers, successors, and assigns, if any, from all claims for any liability, injury, loss, or damage in any way connected with my and/or my child’s participation in the Activity, whether or not caused in whole or in part by the negligence or other misconduct of any of the organization or individuals mentioned above.

Insurance
I also acknowledge that there are inherent risks associated and accompanied with sports and activities and that my child may be injured as a result of an accident arising out of participation in athletics or activities. In consideration for permitting my child named above to participate in sports and/or activities, we release and hold harmless Cristo Rey High School and/or its employees, teachers, coaches, administrators, et al., from any and all liability including, but not limited to liability for injuries or damages sustained by the individual.

I also understand that my child must be covered by medical and/or accident insurance in order to participate in sports. I hereby certify that my child is covered for injuries and/or death occurring as a result of participation in, or the practice for, all athletic events as a student in Cristo Rey High School during the current school year. I also certify that said insurance will be kept in force during the full time that my child engages in the practice for or participation in athletic events during the current school year.

Name of Insurance Company ____________________________ Policy/Group # ____________________________

Events are school sponsored and all school rules will be enforced if there is any unauthorized usage of drugs, alcoholic beverages or other violations of school rules, parents will be notified immediately and appropriate consequences will be implemented by the administration.

I have read this waiver and release of liability. I understand that I have given my substantial right by signing it. I am signing this waiver and release of liability voluntarily. I intend that this waiver and release of liability shall be construed broadly to provide a release and waiver to the maximum extent possible under applicable law.

Printed Name (Parent or Legal Guardian) ____________________________ Signature ____________________________ Date ____________

If the person participating in the activity is not yet 18 years old: As parent or legal guardian of the above-named individual, I verify that I fully understand, agree to, and accept all provisions of this Waiver, Release of Liability and Indemnification.

Printed Name (Parent or Legal Guardian) ____________________________ Signature ____________________________ Date ____________
Preparticipation Physical Evaluation

Date of Exam: ____________________________

Name: ____________________________

Sex: ____________________________

Age: ____________________________

Date of birth: ____________________________

Grade: ____________________________

School: ____________________________

Sport(s): ____________________________

Address: ____________________________

Phone: ____________________________

Personal Physician: ____________________________

In case of emergency, contact: ____________________________

Name: ____________________________

Relationship: ____________________________

Phone (H): ____________________________

Phone (W): ____________________________

Explain "Yes" answers below.
Circle questions you don't know the answers to.

Yes No

1. Has a doctor ever denied or restricted your participation in sports for any reason? ____________

2. Do you have an ongoing medical condition (like diabetes or asthma)? ____________

3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? ____________

4. Do you have allergies to medicines, pollen, foods, or stinging insects? ____________

5. Have you ever passed out or nearly passed out during exercise? ____________

6. Have you ever passed out or nearly passed out after exercise? ____________

7. Have you ever had discomfort, pain, or pressure in your chest during exercise? ____________

8. Does your heart race or skip beats during exercise? ____________

9. Has a doctor ever told you that you have:
   (check all that apply):
   - High blood pressure
   - A heart murmur
   - High cholesterol
   - A heart infection

10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram) ____________

11. Has anyone in your family died for no apparent reason? ____________

12. Does anyone in your family have a heart problem? ____________

13. Has any family member or relative died of heart problems or sudden death before age 60? ____________

14. Does anyone in your family have Marfan syndrome? ____________

15. Have you ever spent the night in a hospital? ____________

16. Have you ever had surgery? ____________

17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? Yes, circle affected area below: ____________

18. Have you had any broken or fractured bones or dislocated joints? Yes, circle below: ____________

19. Have you had a bone or joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, cast, or crutches? Yes, circle below: ____________

20. Have you ever had a stress fracture? ____________

21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? ____________

22. Do you regularly use a brace or assistive device? ____________

23. Has a doctor ever told you that you have asthma or allergies? ____________

24. Do you cough, wheeze, or have difficulty breathing during or after exercise? ____________

25. Is there anyone in your family who has asthma? ____________

26. Have you ever used an inhaler or taken asthma medicine? ____________

27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? ____________

28. Have you had infectious mononucleosis (mono) within the last month? ____________

29. Do you have any rashes, pressure sores, or other skin problems? ____________

30. Have you ever had a herpes skin infection? ____________

31. Have you ever had a head injury or concussion? ____________

32. Have you ever been hit in the head and been confused or lost your memory? ____________

33. Have you ever had a seizure? ____________

34. Do you have headaches with exercise? ____________

35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? ____________

36. Have you ever been unable to move your arms or legs after being hit or falling? ____________

37. When exercising in the heat, do you have severe muscle cramps or become ill? ____________

38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? ____________

39. Have you ever had any problems with your eyes or vision? ____________

40. Do you wear glasses or contact lenses? ____________

41. Do you wear protective eyewear, such as goggles or a face shield? ____________

42. Are you happy with your weight? ____________

43. Are you trying to gain or lose weight? ____________

44. Has anyone recommended you change your weight or eating habits? ____________

45. Do you limit or carefully control what you eat? ____________

46. Do you have any concerns that you would like to discuss with a doctor? ____________

FEMALES ONLY

47. Have you ever had a menstrual period? ____________

48. How old were you when you had your first menstrual period? ____________

49. How many periods have you had in the last 12 months? ____________

Explain "Yes" answers here: ____________

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

Signature of Athlete: ____________________________

Signature of Parent/Guardian: ____________________________

Date: ____________________________

(C)2006 American Academy of Pediatrics, American Academy of Family Physicians, American College of Sports Medicine, American Osteopathic Academy of Sports Medicine, and American Academy of Orthopaedic Surgeons.)
Preparticipation Physical Evaluation

Name ________________________________ Sex _______ Age _______ Date of birth _______

☐ Cleared without restriction
☐ Cleared, with recommendations for further evaluation or treatment for:

__________________________________________

__________________________________________

☐ Not Cleared for ☐ All sports ☐ Certain sports: ____________________________ Reason: ____________________________

Recommendations:

__________________________________________

EMERGENCY INFORMATION

Allergies ____________________________________________________________

Other Information ____________________________________________________

Name of physician (print/type) ___________________________ Date ____________

Address __________________________________________ Phone ______________

Signature of physician __________________________________________ MD or DO

# Preparticipation Physical Evaluation

**Name**

**Date of Birth**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>% Body Fat (optional)</th>
<th>Pulse</th>
<th>BP (<em><strong>/</strong></em>)</th>
</tr>
</thead>
</table>

**Vision**

R 20/___  L 20/___  Corrected: Y N  Pupils: Equal ___  Unequal ___

## MEDICAL

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Eyes/ears/nose/throat</th>
<th>Hearing</th>
<th>Lymph nodes</th>
<th>Heart</th>
<th>Murmurs</th>
<th>Pulses</th>
<th>Lungs</th>
<th>Abdomen</th>
<th>Genitourinary (males only)*</th>
<th>Skin</th>
</tr>
</thead>
</table>

## MUSCULOSKELETAL

<table>
<thead>
<tr>
<th>Neck</th>
<th>Back</th>
<th>Shoulder/arm</th>
<th>Elbow/forearm</th>
<th>Wrist/hand/fingers</th>
<th>Hip/thigh</th>
<th>Knee</th>
<th>Leg/ankle</th>
<th>Foot/toes</th>
</tr>
</thead>
</table>

*Multiple-examiner setup only.

*Having a third party present is recommended for the genitourinary examination.

## Notes:

___________________________________________________________________________

Name of physician (print/type)  

Address  

Signature of physician  

Date  

Phone  

MD or DO