CIF GRADED CONCUSSION SYMPTOM CHECKLIST

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

☒ Baseline Score
☐ Post Concussion Score

- 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.

	None	Mild		Moderate		Severe	
Headache	0	1	2	3	4	5	6
"Pressure in head"	0	1	2	3	4	5	6
Neck Pain	0	1	2	3	4	5	6
Nausea or Vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred Vision	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
"Don't feel right"	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6
Difficulty remembering	0	1	2	3	4	5	6
Fatigue or low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
More emotional than usual	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or Anxious	0	1	2	3	4	5	6
TOTAL SUM OF EACH COLUMN	0						
TOTAL SYMPTOM SCORE *(Sum of all column totals)*							

NAME _____ HIGH SCHOOL _____

D.O.B. _____ SPORT _____ PHYSICIAN (MD/DO) _____

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 behalf of my child,
_____, expressly acknowledge that participation in athletic activities and travel is completely voluntary, and I, on behalf of myself and/or 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 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

Athletic Department • 6200 McMahon Dr • Sacramento, CA 95824-3153
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www.CRHSS.org

(Revised 7/1/05
Mandatory

Preparticipation Physical Evaluation

HISTORY FORM

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, pollens, 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 of sudden death before age 50?	☐	☐
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? If yes, circle affected area below:	☐	☐
18. Have you had any broken or fractured bones or dislocated joints? If 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, a cast, or crutches? If yes, circle below:	☐	☐

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes

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 had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐
32. Have you 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 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_____

Preparticipation Physical Evaluation

CLEARANCE FORM

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

CLEARANCE FORM

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

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Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name _____ Date of Birth _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP ____ / ____ (____ / ____, ____ / ____)

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.
+Having a third party present is recommended for the genitourinary examination.

Notes: _____

_____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO