VOLLEYBALL SIGNUP FORMS
Turn-in deadline: Mon, Feb 27th

Please keep a copy of all paperwork for your records and return the original completed forms to Eckstein's main office by the Feb 27 deadline.

If this is your first Eckstein sport THIS YEAR – Complete ALL parts of ALL forms before turning this completed packet into the main office. The packet must include *clearance by a doctor* and *a date of exam* on the **PreParticipation Physical Evaluation** form.

If you have a physical on file at the school from an Eckstein sport in a previous year (physical date must be within the last two calendar years), but you have NOT participated in a sport THIS YEAR – Complete ALL parts of ALL forms, *except* the three pages of the **PreParticipation Physical Evaluation.** Please write "Physical on File" on those pages.

If you have already been cleared for an Eckstein sport THIS SCHOOL YEAR and there are current forms on file at the school already (including a physical completed within the last two years), you only need to complete the first page of the packet: **PARENT/GUARDIAN RELEASE FORM – VOLLEYBALL SAFETY GUIDELINES.**

Students are not permitted to participate in tryouts or practices until ALL forms have been submitted and a current physical is on file at Eckstein Middle School. If you have questions about athletic forms, please contact Megan Drafall at mpholberg@seattleschools.org or 206-252-5010.

Student's Name: ______________________ **Grade:** __________

PARENT/GUARDIAN RELEASE FORM
Volleyball Safety Guidelines

Seattle Public Schools strives to protect each student-athlete from possible injury while engaging in school activities. The guidelines and information identified below have been established for this activity in order to protect the student-athlete and others from injury and/or illness. Participants and their parents/guardians should recognize that conditioning, nutrition, proper techniques, safety procedures, and well-fitting equipment are important aspects of this training program. Each participant is expected to follow the directions/standards of the coach and must understand that failure to follow such directions or adhere to standards may place the participant at risk.

Travel to and from off-campus facilities shall be in accordance with the directions of Seattle Public Schools field trip policy and the activity coach.

Sport guidelines are as follows:

- Make certain that you wear all equipment that is issued by the coach. Advise the coach of any poorly-fitted or defective equipment.
- Advise the coach if you are ill, have any prolonged symptoms of illness or have been injured.
- Engage in warm-up activities prior to strenuous participation
- Be alert for any physical hazards in the locker room or in or around the participation area. Advise the coach of any hazards or concern.
- Be aware of court surroundings (e.g., obstacles, projections, bleachers, standards, etc.)

The above information has been explained to me and I understand the list of rules and procedures. I also understand the necessity of using the proper techniques while participating in the **Volleyball Program**.

I am aware that **volleyball** is a high-risk sport and that practicing or competing in **volleyball** will be a dangerous and unpredictable activity involving **MANY RISKS OF INJURY**. I understand that the dangers and risk of practicing and competing in **volleyball** include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, blindness, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, muscles, tendons and other aspects of my body, general health and well-being. I understand that the dangers and risk of practicing or competing in **volleyball** may result not only in serious injury, but in a serious impairment of my future abilities to earn a living, to engage in other business, social and recreational activities and generally to enjoy life.

We agree that neither the school district, nor the staff of the Seattle Public Schools, nor the student organization of the Seattle Public Schools shall in any way be held liable for any accident or injury in any way received on account of or while engaged in any athletic activity sponsored by the District. We further agree that neither the District nor any of their staff or student organizations shall be responsible for the payment of any bills rendered for medical services as a result of such accidents or injuries. We also acknowledge that it is our responsibility to provide for any medical, disability or other insurance to mitigate any costs that may be unfortunately incurred as a result of participation in this activity.

By signing below, I certify that I have read the above, understand its content, and agree to its terms.

______________________________ Date: __________
Athlete's Signature

______________________________ Date: __________
Parent/Guardian's Signature

STUDENT ATHLETE REGISTRATION PACKET

Section I: Student Information

Name: ____ Grade: ________
Last First Middle Initial

Student ID: ______________ Birth Date: ___________ Gender: ☐ Female ☐ Male ☐ Other

Home Address: ____
Address Line City/State Zip

Parent/Guardian #1 Name: ________________________ Contact Number: ______________

Parent/Guardian #2 Name: ________________________ Contact Number: ______________

School Attended Last Year: ____
School Name City/State

Private School Student: ◯ Yes ◯ No If yes, school name: ______________________

Section II: Medical Information & Medical Emergency Authorization

Family Doctor: ________________________ Contact Number: ______________

Preferred Hospital: ________________________ Contact Number: ______________

Medications in Use: ____________________ List all allergies: ______________

Emergency Contact: ________________________ Contact Number: ______________

Relationship: ______________

Name of Student Athlete: ________________________ School: ______________

I hereby grant permission to the Athletic Trainer Sports Service Provider and Team Physicians, or other physicians designated by the above named school and Parent/Guardian to provide my child with any medical care or surgical care that they deem reasonably necessary to my child's health and well-being as a result of injuries or other medical conditions occurring as the result of or during athletic activities.

I further authorize the Athletic Trainer Sports Service Providers who are under the direction and guidance of a physician to provide my child with any preventive, first - aid, rehabilitative or emergency treatment they deem reasonably necessary to my child's health and well-being as a result of injuries or other medical conditions occurring as the result of/or during athletic activities.

If reasonably necessary to provide the care described in the preceding two paragraphs, I grant permission to the Athletic Trainer Sports Service Provider and/or school officials to seek necessary treatment at a hospital or health care center.

☒ ____ Date: ___________
Signature of Parent/Guardian

Section III: Parent Consent of Sport Injury Risk

Student may participate in a maximum of three (3) sports, one per sport season. Please indicate your choice(s) by placing a checkmark in the box next to the selected sport(s). **Please attach Sport Risk/Injury Parent Consent forms to approve each chosen sport for your student:**

Fall: ☐ Cross Country ☐ Football ☐ Golf ☐ G. Soccer ☐ G. Swimming ☐ Volleyball (HS) ☐ Ultimate Frisbee (MS)

Winter: ☐ Basketball ☐ Gymnastics ☐ B. Swimming ☐ Wrestling

Spring: ☐ Baseball ☐ B. Soccer ☐ Softball ☐ Tennis ☐ Track ☐ Volleyball (MS)

Other: ☐ (Please List:)

STUDENT ATHLETE REGISTRATION PACKET

Section IV: Mandatory Athletic Insurance

I understand that my student may not participate in boys' or girls' after-school athletics unless he/she is covered by the approved Seattle School District Athletic Insurance Program or by an equivalent plan which provides benefits for loss due to a covered injury with a minimum benefit of $25,000 for each injury including the following minimum provisions:

o Surgery	50% of usual and customary charges/$12,000 maximum
o Physician Visits	$40 per day for first visit and $25 for following visits
o Emergency Room	100%
o X-Rays	60% or up to $500
o MRI and CAT Scan	+80% or up to $500
o Dental	60%

Please check one of the options and then sign below

◯ Option 1: My student is currently enrolled in the approved Seattle School District Student Accident and Health Insurance Program.

OR

◯ Option 2: My student is covered by a plan that is equivalent or better than the above requirements and I will continue to keep it in force throughout the sports season; therefore, I do not wish to enroll my student in the Seattle School District Athletic Insurance Program (high school) or the Seattle School District regular school insurance program (middle school).

____________________________________ ____________________

Name of Company Providing Coverage | Policy Number or Employee Name

☒ ____________________________________ Date: __________

Signature of Parent/Guardian

Section V: Physical Examination

Washington Interscholastic Activities Association (WIAA) regulation 18.13.0 requires that prior to the first practice for participation in interscholastic athletics a student shall undergo a thorough medical examination and be approved for middle level and/or high school interscholastic athletic competition by a medical authority licensed to perform a physical examination.
This physical examination must include, but is not necessarily limited to:

- o Documentation of a detailed review of the student's medical history with special attention to presence or absence of cardiovascular/pulmonary risks and/or previous significant injury and rehabilitation there from.
- o Documentation of satisfactory examination of the cardiopulmonary system.
- o Documentation of satisfactory sport - specific orthopedic screening examination.
- o A written statement by the examiner as to the fitness of the student to undertake the proposed athletic participation, together with suggestions for activity modification if necessary.

WIAA regulation 18.13.5 states that for each subsequent twenty - four **consecutive** months, the student shall furnish a statement or physical examination form signed by a medical authority licensed to perform a physical examination that provides clearance for continued athletic participation.

☒ ____________________________________ Date: __________

Signature of Parent/Guardian

The Seattle School District provides Equal Educational and Employment Opportunity without regard to race, creed, color, national origin, sex, handicap/disability or sexual orientation.

If you have questions regarding the school district's Affirmative Action Policy, call 206-252-0371

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam ____________________

Name ____________________ Date of birth ____________________

Sex ______ Age ________ Grade ________ School ____________________ Sport(s) ____________________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

____

____

____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	○	○
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ____	○	○
3. Have you ever spent the night in the hospital?	○	○
4. Have you ever had surgery?	○	○
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	○	○
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	○	○
7. Does your heart ever race or skip beats (irregular beats) during exercise?	○	○
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: ____	○	○
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)	○	○
10. Do you get lightheaded or feel more short of breath than expected during exercise?	○	○
11. Have you ever had an unexplained seizure?	○	○
12. Do you get more tired or short of breath more quickly than your friends during exercise?	○	○
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?	○	○
14. 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?	○	○
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	○	○
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	○	○
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?	○	○
18. Have you ever had any broken or fractured bones or dislocated joints?	○	○
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?	○	○
20. Have you ever had a stress fracture?	○	○
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)	○	○
22. Do you regularly use a brace, orthotics, or other assistive device?	○	○
23. Do you have a bone, muscle, or joint injury that bothers you?	○	○
24. Do any of your joints become painful, swollen, feel warm, or look red?	○	○
25. Do you have any history of juvenile arthritis or connective tissue disease?	○	○

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?	○	○
27. Have you ever used an inhaler or taken asthma medicine?	○	○
28. Is there anyone in your family who has asthma?	○	○
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	○	○
30. Do you have groin pain or a painful bulge or hernia in the groin area?	○	○
31. Have you had infectious mononucleosis (mono) within the last month?	○	○
32. Do you have any rashes, pressure sores, or other skin problems?	○	○
33. Have you had a herpes or MRSA skin infection?	○	○
34. Have you ever had a head injury or concussion?	○	○
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?	○	○
36. Do you have a history of seizure disorder?	○	○
37. Do you have headaches with exercise?	○	○
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	○	○
39. Have you ever been unable to move your arms or legs after being hit or falling?	○	○
40. Have you ever become ill while exercising in the heat?	○	○
41. Do you get frequent muscle cramps when exercising?	○	○
42. Do you or someone in your family have sickle cell trait or disease?	○	○
43. Have you had any problems with your eyes or vision?	○	○
44. Have you had any eye injuries?	○	○
45. Do you wear glasses or contact lenses?	○	○
46. Do you wear protective eyewear, such as goggles or a face shield?	○	○
47. Do you worry about your weight?	○	○
48. Are you trying to or has anyone recommended that you gain or lose weight?	○	○
49. Are you on a special diet or do you avoid certain types of foods?	○	○
50. Have you ever had an eating disorder?	○	○
51. Do you have any concerns that you would like to discuss with a doctor?	○	○
FEMALES ONLY		
52. Have you ever had a menstrual period?	○	○
53. How old were you when you had your first menstrual period?	○	○
54. 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 ________

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HE0503

9-2681/0410

■ PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name ______________________________ Date of birth ______________

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 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 (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports ______________________
- Reason ______________________

Recommendations ______________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ______________________ Date __________

Address ______________________ Phone __________

Signature of physician ______________________, MD or DO

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HE0503 9-2681/0410

■ PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name ______________________________ Sex ☐ M ☐ F Age __________ Date of birth __________

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

____

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports ______________________________

Reason ______________________________

Recommendations ______________________________

____

____

____

____

____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ______________________________ Date __________

Address ______________________________ Phone __________

Signature of physician ______________________________, MD or DO

EMERGENCY INFORMATION

Allergies ______________________________

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____

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Other information ______________________________

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Seattle Public Schools

Student/Parent Concussion and Sudden Cardiac Arrest Awareness Form

Seattle Public Schools believes participation in athletics improves physical fitness, coordination, self-discipline, and gives students valuable opportunities to learn important social and life skills.

With this in mind it is important that we do as much as possible to create and maintain an enjoyable and safe environment. As a parent/guardian or student you play a vital role in protecting participants and helping them get the best from sport.

Player and parental education in this area is crucial which is the reason for the Concussion Management and Sudden Cardiac Arrest Awareness pamphlet you received. Refer to it regularly.

This form must be signed annually by the parent/guardian and student prior to participation in Seattle Public School athletics. If you have questions regarding any of the information provided in the pamphlet, please contact the athletic director at your school.

I HAVE RECEIVED, READ AND UNDERSTAND THE INFORMATION PRESENTED IN THE CONCUSSION RECOGNITION AND SUDDEN CARDIAC ARREST AWARENESS PAMPHLETS.

______________________	______________________	________
Student Name (Printed)	*Student Name (Signed)*	*Date*
______________________	______________________	________
Parent Name (Printed)	*Parent Name (Signed)*	*Date*

Seattle Public Schools
Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:	
• Headaches • "Pressure in head" • Nausea or vomiting • Neck pain • Balance problems or dizziness • Blurred, double, or fuzzy vision • Sensitivity to light or noise • Feeling sluggish or slowed down • Feeling foggy or groggy • Drowsiness • Change in sleep patterns	• Amnesia • "Don't feel right" • Fatigue or low energy • Sadness • Nervousness or anxiety • Irritability • More emotional • Confusion • Concentration or memory problems (forgetting game plays) • Repeating the same question/comment

Signs observed by teammates, parents and coaches include:
• Appears dazed • Vacant facial expression • Confused about assignment • Forgets plays • Is unsure of game, score, or opponent • Moves clumsily or displays incoordination • Answers questions slowly • Slurred speech • Shows behavior or personality changes • Can't recall events prior to hit • Can't recall events after hit • Seizures or convulsions • Any change in typical behavior or personality • Loses consciousness

What can happen if my child keeps on playing with a concussion or returns too soon?

Seattle Public Schools
Concussion Information Sheet

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often fail to report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents and students is the key to student-athlete's safety.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. The new "Zackery Lystedt Law" in Washington now requires the consistent and uniform implementation of long and well-established return-to-play concussion guidelines that have been recommended for several years:

> "a youth athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time"
>
> and
>
> "…may not return to play until the athlete is evaluated by a licensed heath care provider trained in the evaluation and management of concussion and received written clearance to return to play from that health care provider".

You should also inform your child's coach if you think that your child may have a concussion. Remember it's better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

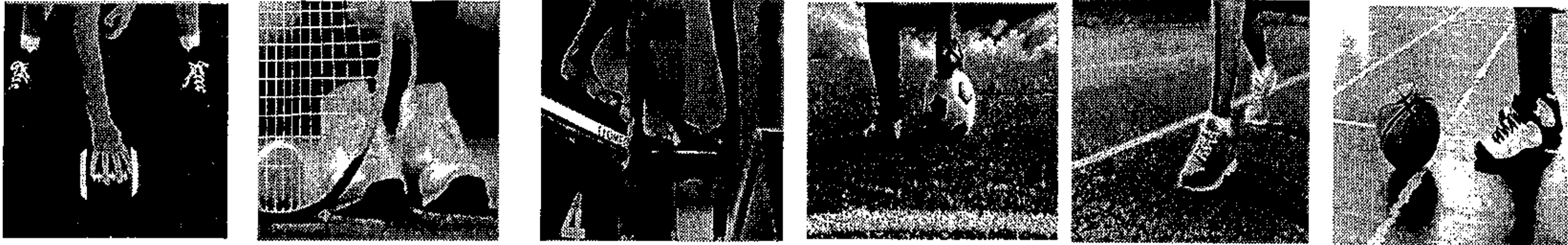
RETURN TO PARTICIPATION PROTOCOL

If you child has been diagnosed with a concussion they MUST follow a progressive return to participation protocol (under the supervision of an approved health care provider) before full participation is authorized.

The return to play protocol may not begin until the participant is no longer showing signs or symptoms of concussion. Once symptom free, the athlete may begin a progressive return to play. This progression begins with light aerobic exercise only to increase the heart rate (5-10 minutes of light jog or exercise bike) and progresses each day as long as the child remains symptom free. If at any time symptoms return, the athlete is removed from participation.

Adapted from the CDC and the 3rd International Conference on Concussion in Sport
Document created 6/15/2009

Sudden Cardiac Arrest
Information Sheet for
Student-Athletes, Coaches and Parents/Guardians
SSB 5083 ~ SCA Awareness Act



What is sudden cardiac arrest? Sudden Cardiac Arrest (SCA) is the sudden onset of an abnormal and lethal heart rhythm, causing the heart to stop beating and the individual to collapse. SCA is the leading cause of death in the U.S. afflicting over 300,000 individuals per year.

SCA is also the leading cause of sudden death in young athletes during sports

---

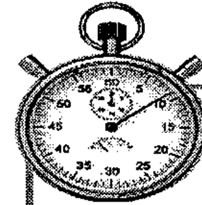
What causes sudden cardiac arrest? SCA in young athletes is usually caused by a structural or electrical disorder of the heart. Many of these conditions are inherited (genetic) and can develop as an adolescent or young adult. SCA is more likely during exercise or physical activity, placing student-athletes with undiagnosed heart conditions at greater risk. SCA also can occur from a direct blow to the chest by a firm projectile (baseball, softball, lacrosse ball, or hockey puck) or by chest contact from another player (called "commotio cordis").

While a heart condition may have no warning signs, some young athletes may have symptoms but neglect to tell an adult. If any of the following symptoms are present, a cardiac evaluation by a physician is recommended:

- Passing out during exercise
- Chest pain with exercise
- Excessive shortness of breath with exercise
- Palpitations (heart racing for no reason)
- Unexplained seizures
- A family member with early onset heart disease or sudden death from a heart condition before the age of 40

How to prevent and treat sudden cardiac arrest? Some heart conditions at risk for SCA can be detected by a thorough heart screening evaluation. However, all schools and teams should be prepared to respond to a cardiac emergency. Young athletes who suffer SCA are collapsed and unresponsive and may appear to have brief seizure-like activity or abnormal breathing (gasping). SCA can be effectively treated by immediate recognition, prompt CPR, and quick access to a defibrillator (AED). AEDs are safe, portable devices that read and analyze the heart rhythm and provide an electric shock (if necessary) to restore a normal heart rhythm.

Remember, to save a life: recognize SCA, call 9-1-1, begin CPR, and use an AED as soon as possible!



Cardiac 3-Minute Drill

1. RECOGNIZE Sudden Cardiac Arrest
- Collapsed and unresponsive
- Abnormal breathing
- Seizure-like activity

2. CALL 9-1-1
- Call for help and for an AED

3. CPR
- Begin chest compressions
- Push hard/ push fast (100 per minute)

4. AED
- Use AED as soon as possible

5. CONTINUE CARE
- Continue CPR and AED until EMS arrives

Be Prepared! Every Second Counts!

UW Medicine
Center For Sports Cardiology
www.uwsportscardiology.org

WASHINGTON INTERSCHOLASTIC ACTIVITIES ASSOCIATION

SCA Awareness
Youth Heart Screening
CPR/AED in Schools

www.nickoftimefoundation.org

Eckstein Middle School
ATHLETICS EMERGENCY CONTACT CARD ("Blue Card")

Student Name (please print)	Grade	______ Male ______ Female

ACTIVITY		
_____ Ultimate Frisbee (Co-Ed)	_____ Boys' Basketball	_____ Track (Co-Ed)
_____ Girls' Soccer	_____ Girls' Basketball	_____ Boys' Soccer
		_____ Girls' Volleyball

EMERGENCY CONTACT INFO	
Address	Phone (Home)
Parent/Guardian	Phone (Cell)
Parent/Guardian	Phone (Cell)
Emergency contact in the event parent/guardian can't be reached:	Emergency Contact Phone
Major medical concerns or allergies	Medication on file with school nurse? _____ YES _____ NO
Insurance Provider	Insurance Policy Number

As parent or legal guardian, I authorize a team coach, school nurse, other school staff or a qualified physician to examine the above-named student and in the event of injury, to administer emergency care and to arrange for any consultation he/she deems necessary to ensure proper care in the event of an injury. Every effort will be made to contact a parent or guardian to explain the nature of the problem prior to any treatment.

I understand that I will assume full responsibility for payment of any services rendered, including transportation by emergency vehicles if necessary.

PARENT/GUARDIAN SIGNATURE ____ **DATE** ____________

PARENT/GUARDIAN EMAIL ____

Nurse's notes: