

# POLICY COMMITTEE

**Committee Members:** Chair – John Luciano, Vice Chair – Michael Gainey, Mark Byrd, Fred Lynch, Joy Warner, Burt Jenkins

**Staff:** Brad Alford

AGENDA ITEM	RECOMMENDATION	SUPPORTING INFORMATION
1. Concussion Protocol (Sports Medicine Advisory Committee) <b>Attachment P1</b>	Approve virtual monitoring as an alternative to face-to-face monitoring for the Concussion Return to Play Protocol .	<p><b>Rationale:</b> Circumstances may arise when there is no LHCP or first responder readily available to supervise a student-athlete's face-to-face monitoring for the Concussion Return to Play Protocol. Virtual monitoring offers a reasonable alternative to ensure safe progression of an athlete through the Concussion Return to Play Protocol.</p> <p><b>Budget Impact:</b> N/A</p> <p><b>Educational Impact:</b> N/A</p> <p><b>Equity Impact:</b> N/A</p> <p><b>Effective Date:</b> Immediately</p>
2. Preparticipation Physical Evaluation (Sports Medicine Advisory Committee) <b>Attachment P2</b>	Approve the Preparticipation Physical Evaluation Monograph, 5 <sup>th</sup> Edition.	<p><b>Rationale:</b> The Preparticipation Physical Evaluation (PPE) Monograph, 5th Edition serves as a practical resource for health care providers to determine athletic medical eligibility, optimize sports participation safety, and promote healthy lifestyles. Developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and the American Osteopathic Academy of Sports Medicine, the Preparticipation Physical Evaluation(PPE) Monograph, 5th Edition is also endorsed by the National Athletic Trainers' Association and the National Federation of State High School Associations.</p> <p><b>Budget Impact:</b> N/A</p> <p><b>Educational Impact:</b> N/A</p> <p><b>Equity Impact:</b> N/A</p> <p><b>Effective Date:</b> 2021-22 School Year</p>

AGENDA ITEM	RECOMMENDATION	SUPPORTING INFORMATION
3. Transfer Policy	Discuss the current Transfer Policy relative to “athletic purposes.”	<p><b>Rationale:</b> The Transfer Committee has heard appeals where “athletic purposes” has been selected by the previous member school. Often the previous member school lacks evidence to support the accusation.</p> <p><b>Budget Impact:</b> N/A</p> <p><b>Educational Impact:</b> N/A</p> <p><b>Equity Impact:</b> N/A</p> <p><b>Effective Date:</b> N/A</p>
4. Academic Requirements	Discuss State Board Policy relative to the second semester eligibility.	<p><b>Rationale:</b> Member schools have expressed concerns relative to student’s not performing well in the virtual setting. Some student’s do not have access to resources for virtual learning.</p> <p><b>Budget Impact:</b> N/A</p> <p><b>Educational Impact:</b> N/A</p> <p><b>Equity Impact:</b> N/A</p> <p><b>Effective Date:</b> N/A</p>
5. Event Security	Discuss policies and procedure relative to required law enforcement at contest. NCHSAA Handbook 2.5.3(a)	<p><b>Rationale:</b> Per state mandates, minimal spectators will be allowed at contest. The reduction in spectators should decrease (1) the opportunity for an emergency; and (2) gate revenue. Member schools are concerned about the financial toll this may create.</p> <p><b>Budget Impact:</b> N/A</p> <p><b>Educational Impact:</b> N/A</p> <p><b>Equity Impact:</b> N/A</p> <p><b>Effective Date:</b> N/A</p>
6. Lighting Standards Attachment P3	Discuss the implementation of checklist approval.	<p><b>Rationale:</b> The checklist is recommended for 2020-21 and required for 2021-22.</p> <p><b>Budget Impact:</b> N/A</p> <p><b>Educational Impact:</b> N/A</p> <p><b>Equity Impact:</b> N/A</p> <p><b>Effective Date:</b> N/A</p>

# NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION

## Meeting of the Board of Directors – Agenda Item Submission

**School/LEA/Conference/Group:** Sports Medicine Advisory Committee (SMAC)

The Sports Medicine Advisory Committee recommends to the BOD that virtual monitoring of student-athletes who have sustained a concussion beginning immediately.

**Recommendation/Proposal:**

The NCHSAA Sports Medicine Advisory Committee recommends adoption of the NCHSAA Virtually Monitored Concussion RTP Protocol. The NCHSAA Virtually Monitored Concussion RTP Protocol will complement the already established NCHSAA Concussion Return to Play (RTP) Protocol (face-to-face).

- The NCHSAA Concussion Return to Play (RTP) Protocol (in-person) OR the NCHSAA Virtually Monitored Concussion RTP is **REQUIRED** to be completed in its entirety for any concussed student-athlete (SA) before they are released to resume participation in athletics. A step-by-step progression of physical and cognitive exertion is widely accepted as the appropriate approach to ensure a concussion has resolved, and that a student-athlete can return to athletics safely. Both the NCHSAA Concussion (RTP) Protocol and NCHSAA Virtually Monitored Concussion (RTP) Protocol have been designed using this step-by-step progression.
- The NCHSAA Virtually Monitored Concussion (RTP) Protocol can be monitored by any of the following LHCP: Licensed Physician, Licensed Athletic Trainer, Licensed Physician Assistant, Licensed Nurse Practitioner or a Licensed Neuropsychologist.
- The LHCP may elect to use a combination of in-person monitoring and virtual monitoring to complete the required stages within the RTP progression. Both in-person and virtual stage monitoring outcomes can be documented on this form.
- After monitored completion of each stage without provocation/recurrence of signs and/or symptoms, a student- athlete is allowed to advance to the next stage of activity. The length of time for each stage is at least 24hours. A separate stage specific in-person/virtual consult checklist is to be completed for each RTP stage.
- An adult observer must be present with the SA during each stage to provide consent and assist with emergency care if needed.
  - Rationale: Circumstances may arise when there is no LHCP or first responder readily available to supervise a SAs Concussion Return to Play (RTP) Protocol (face-to-face). In those instances, the NCHSAA Virtually Monitored Concussion RTP Protocol offers a reasonable alternative to ensure safe progression of an athlete through the concussion RTP protocol.
  - Budget Impact: None
  - Educational Impact: None
  - Gender Impact: This proposal is equitable to both males and females.
  - Effective Date: Immediately

Signature\_\_\_\_\_ Date\_\_\_\_\_



## NCHSAA Virtually Monitored Concussion Return to Play Protocol

- The NCHSAA Concussion Return to Play (RTP) Protocol (in-person) OR the NCHSAA Virtually Monitored Concussion RTP is **REQUIRED** to be completed in its entirety for any concussed student-athlete (SA) before they are released to resume participation in athletics. A step-by-step progression of physical and cognitive exertion is widely accepted as the appropriate approach to ensure a concussion has resolved, and that a student-athlete can return to athletics safely. Both the NCHSAA Concussion (RTP) Protocol and NCHSAA Virtually Monitored Concussion (RTP) Protocol have been designed using this step-by-step progression.
- The NCHSAA Virtually Monitored Concussion (RTP) Protocol can be monitored by any of the following LHCP: Licensed Physician, Licensed Athletic Trainer, Licensed Physician Assistant, Licensed Nurse Practitioner or a Licensed Neuropsychologist.
- The LHCP may elect to use a combination of in-person monitoring and virtual monitoring to complete the required stages within the RTP progression. Both in-person and virtual stage monitoring outcomes can be documented on this form.
- After monitored completion of each stage without provocation/recurrence of signs and/or symptoms, a student-athlete is allowed to advance to the next stage of activity. The length of time for each stage is at least 24 hours. A separate stage specific in-person/virtual consult checklist is to be completed for each RTP stage.
- An adult observer must be present with the SA during each stage to provide consent and assist with emergency care if needed.

Stage	Activity	Objective	Stage Specific Virtual Consult Checklist Completed/ In-Person Monitored
1	20-30 min of cardio activity: walking, stationary bike	Perceived intensity/exertion: Light Activity	<input type="checkbox"/> YES    DATE _____ <input type="checkbox"/> YES    In-Person Monitored
2	30 min of cardio activity: jogging at medium pace. Body weight resistance exercise (e.g. Push-ups, lunge walks) with minimum head rotation x25 each.	Perceived intensity/exertion: Moderate Activity	<input type="checkbox"/> YES    DATE _____ <input type="checkbox"/> YES    In-Person Monitored
3	30 min of cardio activity: running at fast pace, incorporate intervals. Increase repetitions of body weight resistance exercise (e.g. Sit-ups, push-ups, lunge walks) x 50 each. Sport specific agility drills in three planes of movement.	Perceived intensity/exertion: Hard activity, changes of direction with increased head and eye movement	<input type="checkbox"/> YES    DATE _____ <input type="checkbox"/> YES    In-Person Monitored
4	Participate in non-contact practice drills. Warm-up and stretch x10 min. Intense, non-contact, sport specific agility drills x 30-60 minutes.	Perceived intensity/exertion: High/Maximum Effort Activity	<input type="checkbox"/> YES    DATE _____ <input type="checkbox"/> YES    In-Person Monitored
5	Participate in full practice. If in a contact sport, controlled contact practice allowed.		PARENT/GUARDIAN <input type="checkbox"/> YES    DATE _____
<b>**If needed, Parent/Legal Custodian may act as proxy for monitoring of Stage 5 (full practice) of RTP. However, if this is the case, a final virtual visit with supervising LHCP is required. Stage 5 form should be completed by parent/legal custodian.</b>			
Final LHCP Virtual Visit	The LHCP overseeing the SA's care will review RTP in its entirety (including Stage 5). If any concussion signs or symptoms occur during stage 5, the SA is required to return to the treating LHCP.  The Virtually Monitored RTP Packet and the RTP Form MUST be signed by supervising LHCP before the SA is allowed to resume full participation in athletics.		<input type="checkbox"/> YES    DATE _____ <input type="checkbox"/> YES    In-Person Monitored

**The LHCP who monitored the student athlete's RTP Protocol MUST sign and date below when stage 5 is successfully completed.**  
 By signing below, I attest that I have monitored the above-named student-athlete's return to play protocol through stage 5.

\_\_\_\_\_  
 Signature of Licensed Physician, Licensed Athletic trainer, Licensed Physician Assistant,  
 Licensed Nurse Practitioner, Licensed Neuropsychologist (please circle)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Please print name





## NCHSAA Virtually Monitored Concussion RTP Protocol - VIRTUAL CONSULT CHECKLIST – STAGE 1

ATHLETE NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ ADULT OBSERVER: \_\_\_\_\_  
 DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ MONITORED BY: \_\_\_\_\_ (circle one) MD/DO LAT PA NP

- ☐ Conducted through a video telemedicine source with double identification verified. Athlete & adult voice understanding and consent to proceed with exertional stage via interactive audio and video telemedicine source.
- ☐ Review of athlete's overall function with activities of daily living (cognitive and physical): \_\_\_\_\_% normal

Comment:

☐ **Pre-Exercise Symptom Questionnaire**

- Review and report symptoms the athlete is experiencing in the last 24 hours BEFORE starting RTP stage
- If athlete reports symptoms BEFORE or DURING exercise, session should NOT continue. Notification of and consultation with supervising physician is recommended.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Other:		
Sensitivity to light			Confusion					

**Monitored Observation of RTP Stage – Light Activity**

20-30 minutes of cardio activity (walking/stationary bike):

☐ **Post-Exercise Symptom Questionnaire**

- Review and report symptoms the athlete is experiencing AFTER completing RTP stage.
- If athlete reports symptoms AFTER exercise or 24 hours following, notification of and consultation with supervising physician is recommended.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Comment:		
Sensitivity to light			Confusion					

- ☐ Education on monitoring for red flags
- ☐ Establish plan for next virtually supervised visit – DATE \_\_\_\_\_ TIME \_\_\_\_\_ CONFIRMED BY \_\_\_\_\_





## NCHSAA Virtually Monitored Concussion RTP Protocol - VIRTUAL CONSULT CHECKLIST – STAGE 2

ATHLETE NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ ADULT OBSERVER: \_\_\_\_\_  
 DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ MONITORED BY: \_\_\_\_\_ (circle one) MD/DO LAT PA NP

- ☐ Conducted through a video telemedicine source with double identification verified. Athlete & adult voice understanding and consent to proceed with exertional stage via interactive audio and video telemedicine source.
- ☐ Review of athlete's overall function with activities of daily living (cognitive and physical): \_\_\_\_\_ % normal

Comment:

☐ **Pre-Exercise Symptom Questionnaire**

- Review and report symptoms the athlete is experiencing in the last 24 hours BEFORE starting RTP stage
- If athlete reports symptoms BEFORE or DURING exercise, session should NOT continue. Notification of and consultation with supervising physician is recommended.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Other:		
Sensitivity to light			Confusion					

☐ **Monitored Observation of RTP Stage – Moderate Activity**

30 min of cardio activity (jogging at medium pace):

Body weight resistance exercise with minimum head rotation (eg. Push-ups, lunge walks):

☐ **Post-Exercise Symptom Questionnaire**

- Review and report symptoms the athlete is experiencing AFTER completing RTP stage.
- If athlete reports symptoms AFTER exercise or 24 hours following, notification of and consultation with supervising physician is recommended.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Comment:		
Sensitivity to light			Confusion					

- ☐ Education on monitoring for red flags

☐ Establish plan for next virtually supervised visit – DATE \_\_\_\_\_ TIME \_\_\_\_\_ CONFIRMED BY \_\_\_\_\_





### NCHSAA Virtually Monitored Concussion RTP Protocol - VIRTUAL CONSULT CHECKLIST – STAGE 3

ATHLETE NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ ADULT OBSERVER: \_\_\_\_\_  
 DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ MONITORED BY: \_\_\_\_\_ (circle one) MD/DO LAT PA NP

- ☐ Conducted through a video telemedicine source with double identification verified. Athlete & adult voice understanding and consent to proceed with exertional stage via interactive audio and video telemedicine source.
- ☐ Review of athlete's overall function with activities of daily living (cognitive and physical): \_\_\_\_\_% normal

Comment:

☐ **Pre-Exercise Symptom Questionnaire**

- Review and report symptoms the athlete is experiencing in the last 24 hours BEFORE starting RTP stage
- If athlete reports symptoms BEFORE or DURING exercise, session should NOT continue. Notification of and consultation with supervising physician is recommended.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Other:		
Sensitivity to light			Confusion					

- ☐ **Monitored Observation of RTP Stage -** Hard activity, changes of direction with increased head and eye movement

30 min of cardio activity: (running at fast pace, incorporate intervals)

Increase repetitions of body weight resistance exercise (eg. Sit-ups, push-ups, lunge walks):

Sport specific agility drills in three planes of movement:

☐ **Post-Exercise Symptom Questionnaire**

- Review and report symptoms the athlete is experiencing AFTER completing RTP stage.
- If athlete reports symptoms AFTER exercise or 24 hours following, notification of and consultation with supervising physician is recommended.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Other:		
Sensitivity to light			Confusion					

- ☐ Education on monitoring for red flags

- ☐ Establish plan for next virtually supervised visit – DATE \_\_\_\_\_ TIME \_\_\_\_\_ CONFIRMED BY \_\_\_\_\_





## NCHSAA Virtually Monitored Concussion RTP Protocol - VIRTUAL CONSULT CHECKLIST – STAGE 4

ATHLETE NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ ADULT OBSERVER: \_\_\_\_\_  
 DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ MONITORED BY: \_\_\_\_\_ (circle one) MD/DO LAT PA NP

- ☐ Conducted through a video telemedicine source with double identification verified. Athlete & adult voice understanding and consent to proceed with exertional stage via interactive audio and video telemedicine source.
- ☐ Review of athlete's overall function with activities of daily living (cognitive and physical): \_\_\_\_\_% normal

Comment:

☐ **Pre-Exercise Symptom Questionnaire**

- Review and report symptoms the athlete is experiencing in the last 24 hours BEFORE starting RTP stage
- If athlete reports symptoms BEFORE or DURING exercise, session should NOT continue. Notification of and consultation with supervising physician is recommended.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Other:		
Sensitivity to light			Confusion					

☐ **Monitored Observation of RTP Stage – High/Maximum Effort Activity**

Warm-up and stretch x10 min:

Participate in non-contact practice drills. Intense, non-contact, sport specific agility drills x 30-60 minutes:

**Post-Exercise Symptom Questionnaire**

- Review and report symptoms the athlete is experiencing AFTER completing RTP stage.
- If athlete reports symptoms AFTER exercise or 24 hours following, notification of and consultation with supervising physician is recommended.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Comment:		
Sensitivity to light			Confusion					

- ☐ Education on monitoring for red flags
- ☐ Reviewed stage 5 paperwork to be completed by supervising parent/adult
- ☐ Establish plan for next virtually supervised visit – DATE \_\_\_\_\_ TIME \_\_\_\_\_ CONFIRMED BY \_\_\_\_\_





# **NCHSAA Virtually Monitored Concussion RTP Protocol - VIRTUAL CONSULT CHECKLIST – STAGE 5** **(To be completed by supervising parent/legal custodian/adult)**

ATHLETE NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

SUPERVISING PARENT/LEGAL CUSTODIAN/ADULT \_\_\_\_\_

- ☐ Review of athlete's overall function with activities of daily living (cognitive and physical): \_\_\_\_\_ % normal

Comment:

☐ **Pre-Exercise Symptom Questionnaire**

- Review and report symptoms the athlete is experiencing in the last 24 hours BEFORE starting RTP stage
- If athlete reports symptoms BEFORE or DURING exercise, session should NOT continue. Notification of and consultation with supervising physician is recommended.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Other:		
Sensitivity to light			Confusion					

- ☐ **Monitored Observation of RTP Stage 5** – Participate in full practice. SPORT: \_\_\_\_\_
- ☐ A "Stage 5 equivalent" workout that incorporates high intensity, high heart rate activity that challenges the vestibular, visual, and cognitive systems can be substituted when there is not an opportunity to participate in a team-based practice.

Please describe in detail the practice/workout activities that the athlete participated in.

**Post- Exercise Symptom Questionnaire**

- Review and report symptoms the athlete is experiencing AFTER completing RTP stage.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Comment:		
Sensitivity to light			Confusion					

\*If athlete reports symptoms AFTER exercise or 24 hours following, notification of supervising physician is recommended.

**I certify that I supervised this athlete during stage 5 of the RTP protocol and that the information documented above is complete and accurate. SIGNATURE OF SUPERVISING PARENT/LEGAL CUSTODIAN/ADULT: \_\_\_\_\_**

- ☐ Contact supervising LAT/LHCP to schedule virtual visit for final clearance – DATE \_\_\_\_\_ TIME \_\_\_\_\_



**NCHSAA Virtually Monitored Concussion RTP Protocol – FINAL VIRTUAL CONSULT CHECKLIST**  
(To be completed by supervising LHCP)

ATHLETE NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ ADULT OBSERVER: \_\_\_\_\_  
DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ REVIEWED BY: \_\_\_\_\_ (circle one) MD/DO LAT PA NP

- ☐ Conducted through a video telemedicine source with double identification verified. Athlete & adult voice understanding and consent to proceed with visit via interactive audio and video telemedicine source.
- ☐ Review of athlete's overall function with activities of daily living (cognitive and physical): \_\_\_\_\_ % normal

Comment:

☐ **Symptom Questionnaire**

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Other:		
Sensitivity to light			Confusion					

- ☐ **Review of RTP Stage 5 – Participate in Full Practice**

Comment:

☐ **Additional Comments:**

- ☐ Athlete has successfully completed all 5 stages of the RTP protocol without recurrence of concussion related symptoms.
- ☐ Athlete has returned to pre-injury function level and reports no concussion related clinical signs and symptoms at rest and with cognitive stimulation (schoolwork, reading, computer work).
- ☐ NCSHAA Gfeller Waller Virtually Monitored RTP Protocol Packet completed and kept on file.
- ☐ The RTP Form is completed and kept on file.





**RETURN TO PLAY FORM:  
CONCUSSION MEDICAL CLEARANCE RELEASING THE  
STUDENT-ATHLETE TO  
RESUME FULL PARTICIPATION IN ATHLETICS**

This form must be signed by one of the following examining Licensed Health Care Providers (LHCP) identified in the Gfeller-Waller Concussion Awareness Act before the student-athlete is allowed to resume full participation in athletics: Licensed Physician (MD/DO), Licensed Athletic Trainer (LAT), Licensed Physician Assistant (PA), Licensed Nurse Practitioner (NP), or Licensed Neuropsychologist. This form must be signed by the student-athlete's parent/legal custodian giving their consent before their child resumes full participation in athletics.

Name of Student-Athlete: \_\_\_\_\_ Sport: \_\_\_\_\_ Male/Female

DOB: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Date Concussion Diagnosed: \_\_\_\_\_

This is to certify that the above-named student-athlete has been evaluated and treated for a concussion and that the Return to Play Protocol was monitored by:

\_\_\_\_\_ at \_\_\_\_\_  
(Print Name of Person and Credential) (Print Name of School)

As the examining LHCP, I attest that the above-named student-athlete is now reporting to be completely free of all clinical signs and reports he/she is entirely symptom-free at rest and with both full cognitive and full exertional/physical stress and that the above-named student-athlete has successfully completed the required NCHSAA Concussion Return to Play Protocol through stage 5. By signing below therefore, I give the above-named student-athlete consent to resume full participation in athletics.

*It is critical that the medical professional ultimately releasing this student-athlete to return to athletics after a concussion has appropriate expertise and training in concussion management. The NCHSAA, therefore, STRONGLY RECOMMENDS that in concussion cases, Licensed Athletic Trainers, Licensed Physician Assistants, Licensed Nurse Practitioners, consult with their supervising physician before signing this Return To Play Form, as per their respective state statutes.*

Signature of Licensed Physician, Licensed Athletic Trainer, Licensed Physician Assistant,  
Licensed Nurse Practitioner, Licensed Neuropsychologist (Please Circle)

\_\_\_\_\_ Date

\_\_\_\_\_ Please Print Name

\_\_\_\_\_ Please Print Office Address

\_\_\_\_\_ Phone Number

**Parent/Legal Custodian Consent for Their Child to Resume Full Participation in Athletics**

I am aware that the NCHSAA **REQUIRES** the consent of a child's parent or legal custodian prior to them resuming full participation in athletics after having been evaluated and treated for a concussion. I acknowledge that the Licensed Health Care Provider above has overseen the treatment of my child's concussion and has given their consent for my child to resume full participation in athletics. By signing below, I hereby give my consent for my child to resume full participation in athletics.

\_\_\_\_\_ Signature of Parent/Legal Custodian

\_\_\_\_\_ Date

\_\_\_\_\_ Please Print Name and Relationship to Student-Athlete

Approved for 2020-2021 School Year

# NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION

## Meeting of the Board of Directors – Agenda Item Submission

**School/LEA/Conference/Group:** Sports Medicine Advisory Committee (SMAC)

The Sports Medicine Advisory Committee recommends to the BOD that the Preparticipation Physical Evaluation (PPE) Monograph history, physical, and medical eligibility forms be required for NCHSAA student-athletes beginning with the 2021-2022 academic year, with updates being utilized as they are produced.

Recommendation/Proposal:

The NCHSAA Sports Medicine Advisory Committee recommends adoption of the to the Preparticipation Physical Evaluation (PPE) Monograph history, physical, and medical eligibility forms be required for NCHSAA student-athletes beginning with the 2021-2022 academic year, with updates being utilized as they are produced. The Monograph PPE contains a student-athlete (SA) history form and a physical examination form and a Family Educational Rights and Privacy Act (FERPA) compliant medical eligibility form. Prior to the physical examination the SA history form must be completed and signed by a parent or legal custodian if the SA is younger than 18 years of age. The physical examination and medical eligibility forms must be completed by Qualified Medical Personnel (QMP) which are a licensed Physician (MD/DO), licensed Physician Assistant (PA), or a licensed Nurse Practitioner (NP). It is the opinion of the SMAC that the SA history, physical examination, and medical eligibility must be completed annually.

- Rationale: The Preparticipation Evaluation (PPE) is intended to promote health and safety of SAs during training and competition. It has typically been considered a screening tool for injuries, illnesses or factors that might place SAs or others at risk. The author societies for the 5<sup>th</sup> Edition Monograph PPE include the American Academy of Pediatrics, American Academy of Family Physicians, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine and, American Osteopathic Academy of Sports Medicine. In addition, both the National Athletic Trainers' Association (NATA) and National Federation of State High School Associations also endorse the AAP PPE.
- Budget Impact: None
- Educational Impact: None
- Gender Impact: This proposal is equitable to both males and females.
- Effective Date: 2021-2022 School Year

Signature \_\_\_\_\_ Date \_\_\_\_\_



## ■ PREPARTICIPATION PHYSICAL EVALUATION

### PHYSICAL EXAMINATION FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

#### PHYSICIAN REMINDERS

- 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, e-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-enhancing 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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ ( _____ / _____ )	Pulse: _____	Vision: R 20/ _____ L 20/ _____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul>		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>		
Lymph nodes		
Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> <li>Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis</li> </ul>		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional <ul style="list-style-type: none"> <li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>		

<sup>a</sup> Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA



## ■ PREPARTICIPATION PHYSICAL EVALUATION

### MEDICAL ELIGIBILITY FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

\_\_\_\_\_  
\_\_\_\_\_

☐ Medically eligible for certain sports

\_\_\_\_\_  
\_\_\_\_\_

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

### SHARED EMERGENCY INFORMATION

Allergies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Other information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Emergency contacts: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



## ■ PREPARTICIPATION PHYSICAL EVALUATION

### HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Sex assigned at birth (F, M, or intersex): \_\_\_\_\_ How do you identify your gender? (F, M, or other): \_\_\_\_\_

List past and current medical conditions. \_\_\_\_\_

Have you ever had surgery? If yes, list all past surgical procedures. \_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). \_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). \_\_\_\_\_

#### Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)		
	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU		
	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)		
	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		
	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		







## Lighting Standards: Implementation of Annual Maintenance Checklist

Board approved the following at the May 2020 meeting:

*To require member schools to complete a "System Operation and Maintenance Checklist" form on an annual basis to ensure that electrical and structural components of facility lighting systems are up to code with NEC (National Electrical Code) and IBC (International Building Code) standards.*

- *Deadline to complete the Checklist form will be prior to participation in the playoffs but staff recommends conducting annually in summer months when students are absent from campus*
- *Initial focus is on electrical and structural components.*
- *Penalty for failure to complete the required Checklist form: The school cannot host a playoff event due to failure to comply with minimum electrical and structural requirements deemed safe for operation*
- *Recommend use of the Checklist in 2020-2021 school year*
- *Mandatory use of the Checklist in 2021-2022 school year*

Since May, the following have been put in place to guide schools in use of the Checklist:

1. Musco provided resources
  - Musco created [training video](#) to aid schools in conducting the [safety checklist](#)
  - Sport-specific [Lighting Performance](#) worksheets are available on-line (this is the baseball worksheet as an example)
2. NCHSAA staff promotions
  - Virtual Regional Meetings
  - Weekly Tuesday Updates e-blasts
  - ['Button'](#) on NCHSAA Lighting Standards page so schools can email questions, comments directly to Musco representatives

# ANNUAL SYSTEM OPERATION & MAINTENANCE CHECKLIST

School Name \_\_\_\_\_ Field Name \_\_\_\_\_

Date of Inspection \_\_\_\_\_ Voltage/Phase \_\_\_\_\_ Date Installed \_\_\_\_\_

Type of Pole \_\_\_\_\_ Type/# of Luminaires \_\_\_\_\_

Inspected By \_\_\_\_\_ Title: \_\_\_\_\_ Contact Number \_\_\_\_\_

	OK	Needs Repair	N/A	Notes
<b>Lighting Performance Testing</b>				
Check with the AD and Staff to see if there are any concerns regarding field (pole, electrical or lighting)				
Average maintained footcandles meet guidelines				
Uniformities meet guidelines				
<b>Service Entrance, Poles, and Distribution Boxes</b>				
Warning Stickers, wiring diagrams, circuit labels should be posted and legible				
Snap all breakers on and off several times to ensure firm contact. Utilizing breakers for on/off control is not recommended due to reducing the effectiveness of the devices for overcurrent protection. Also, risk of arc flash is increased as breakers age and appropriate precautions should be taken.* See NEC 110.16-A Arc Flash				
Check fuses for continuity*				
Insulation around wiring should show no signs of deterioration*				
Wiring should show no heat discoloration*				
Signs of wear should be replaced on taped connections*				
Bare wires and exposed connections should be wrapped with insulated covering*				
Are the panels appropriately locked or access minimized from the public				
Check all grounding connections at service entrance and at poles. The grounding systems are required to comply with NFPA 70.* 1. Is a ground rod present? 2. Are the bolted connections in good condition? 3. Are the grounding components from acceptable materials and are they sized properly? 4. Is the resistance level satisfactory? This can be verified by measuring resistance to ground. Which for a single rod it should be 25 ohms or less. If it's higher, then a second ground rod shall be added. There is no requirement for minimum resistance value, if two grounds are installed.				
<b>Pole Structures</b>				
Wood poles checked for leaning and resulting misalignment of luminaires				
Wood poles checked for twisting and resulting misalignment of luminaires				
Wood poles checked for decay. Just below ground level, woodpecker holes etc.				
Steel anchor bolt poles checked for signs of corrosion				
Steel anchor bolt poles checked for proper drainage in grout at base				
Direct burial steel poles checked for proper mastic covering above/below grade at base to ensure no corrosion or pitting of the galvanized protection is evident				
Direct burial steel poles checked for water/moisture inside pole and corrosion around base of pole				
Direct burial steel poles checked for proper mastic covering inside the pole				
Pull on conduits in hand holes to check for looseness*				
Check for all pole electrical access covers in place				
Check for all external cable conduit to be in good shape, not cracked or missing*				
Check for other visible signs of deterioration? Specify				
Check any pole climbing equipment for proper attachment, alignment and decay or corrosion				
Check to make sure trees are not encroaching on the pole structures or overhead wires				
<b>Luminaires</b>				
Check for signs of smoky film on lenses, or water damage to luminaires				
Check for broken or missing lenses, replace as needed				
Check for luminaires not operating. Troubleshoot and repair (fuse, lamp, ballast or capacitor for HID)*				
Visually inspect ballast/drivers for signs of deterioration				
Do any of the luminaires need realignment (visual and light level testing)				
Insulation covering on wiring should show no signs of wear or cracking*				
Ground wire connections must be secure*				
Check around ballasts for signs of blackening. (metal halide)				
Check that capacitors aren't bulging. (metal halide)				
Check aiming alignment of all luminaires.				
On wooden poles, see if crossarms are still aligned with the field and horizontal.				

\*These tests and/or repairs require the services of a qualified electrician.





## Lighting Performance: Football

### Horizontal

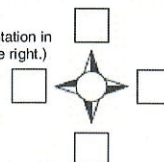
Date of Readings: \_\_\_\_\_ By: \_\_\_\_\_  
School Name: \_\_\_\_\_ Seating Capacity: \_\_\_\_\_  
School Contact: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Email: \_\_\_\_\_  
Facility Name: \_\_\_\_\_  
Facility Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Mark your approximate pole locations around the field to the right, if applicable with an "X".

Recommended average light levels:  
Less than 2,000 spectators: 30 footcandles  
2,000-5,000 spectators: 50 footcandles  
5000+ spectators: 100 footcandles

Recommended uniformity:  
Less than 2,000 spectators: 3:1  
2,000-5,000 spectators: 2:1  
5,000+ spectators: 1.7:1

Field Orientation:  
(Please indicate field orientation in cells around diagram to the right.)



This form will automatically calculate light levels and uniformities if used electronically.

If calculating manually:

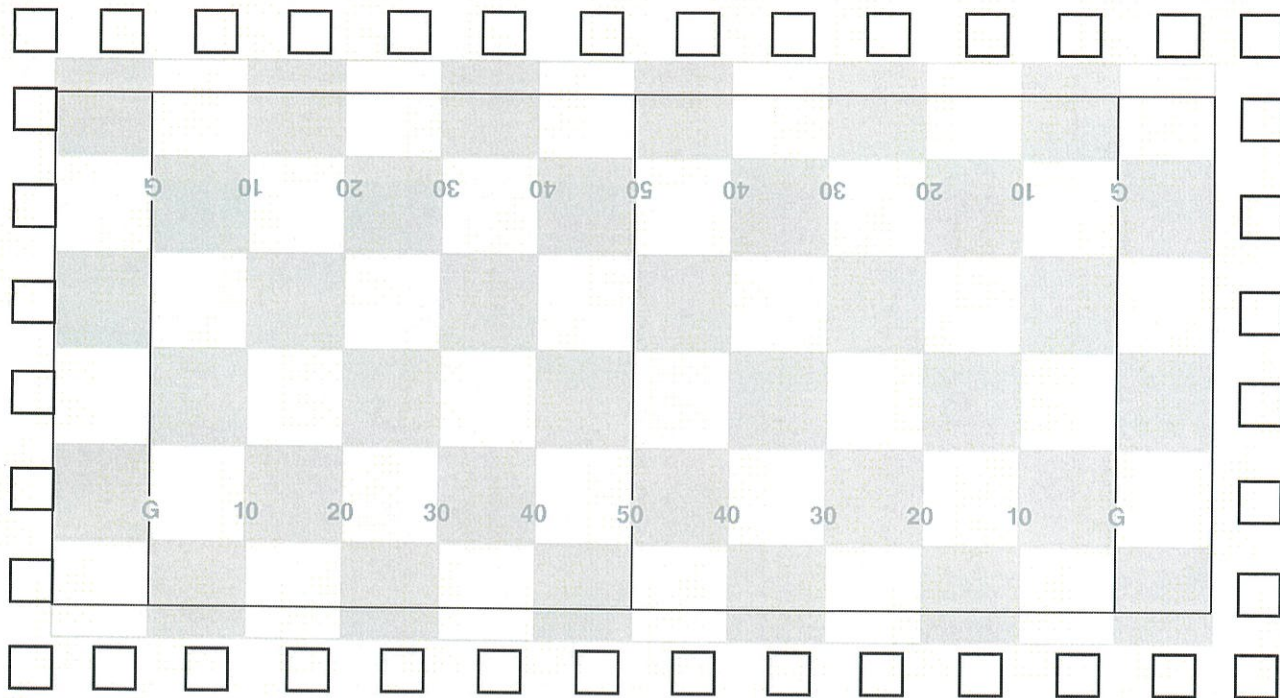
Add the grid point readings and divide by the number of total grid points to get your light level average.

Divide the highest reading by your lowest reading to get your uniformity.

30' x 30' grid



Readings taken in center of grid area.



Horizontal Light Level and Field Survey Results:	
Average light levels: _____	How is lighting controlled: _____
Uniformity: _____ :1	Date lighting equipment installed: _____
(If outdoor) Quantity of poles: _____	Lighting manufacturer: _____
Field size: _____	Relamp / maintenance date: _____
Total number luminaires: _____	Maintenance performed by: _____
Number luminaires operational: _____	Annual hours of operation: _____
Luminaire type (HID or LED): _____	Light meter brand: _____
Lamp wattage: _____	Model number: _____
	Calibration date: _____





# Lighting Performance: Volleyball

Horizontal

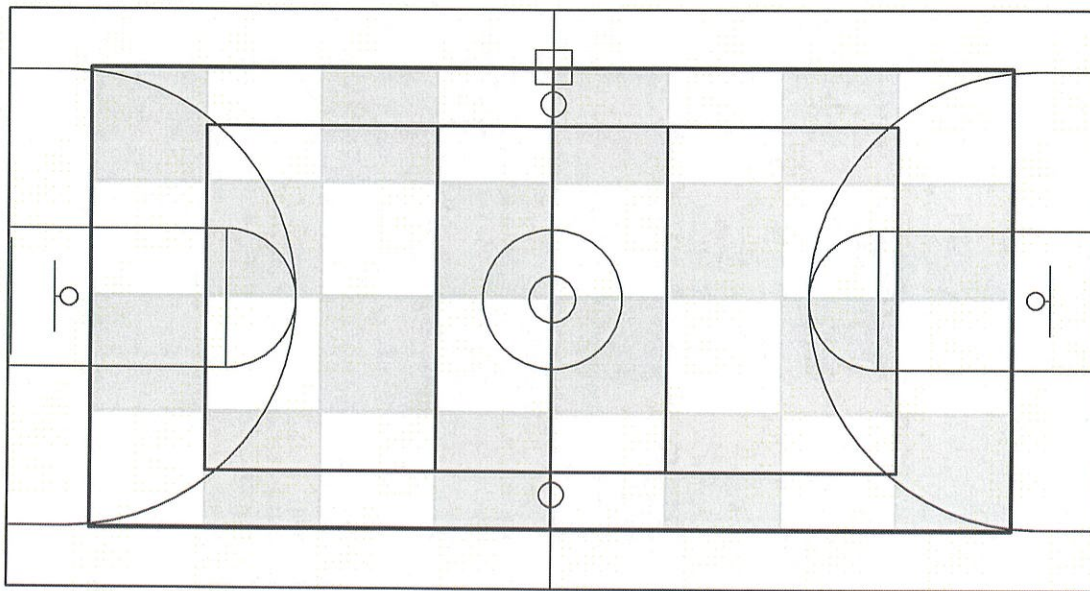
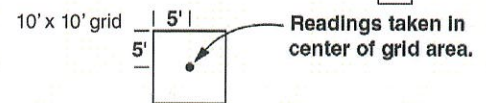
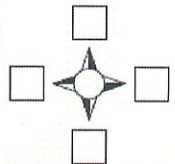
Date of Readings: \_\_\_\_\_ By: \_\_\_\_\_  
School Name: \_\_\_\_\_ Seating Capacity: \_\_\_\_\_  
School Contact: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Email: \_\_\_\_\_  
Facility Name: \_\_\_\_\_  
Facility Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Recommended average light levels: 80 footcandles  
Recommended uniformity: 2.5:1

This form will automatically calculate light levels and uniformities if used electronically.

If calculating manually:  
Add the grid point readings and divide by the number of total grid points to get your light level average.  
Divide the highest reading by your lowest reading to get your uniformity.

Court Orientation:  
(Please indicate court orientation in cells around diagram to the right.)



Horizontal Light Level and Field Survey Results:	
Average light levels: _____	Date lighting equipment installed: _____
Uniformity: _____ :1	Lighting manufacturer: _____
Total number luminaires: _____	Relamp / maintenance date: _____
Number luminaires operational: _____	Maintenance performed by: _____
Luminaire type (HID or LED): _____	Annual hours of operation: _____
Lamp wattage: _____	Light meter brand: _____
How is lighting controlled: _____	Model number: _____
	Calibration date: _____