

POLICY COMMITTEE

Committee Members: John Luciano (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) Attachment P1	Approve virtual monitoring as an alternative to face-to-face monitoring for the Concussion Return to Play Protocol .	<p>Rationale: 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>Budget Impact: N/A</p> <p>Educational Impact: N/A</p> <p>Equity Impact: N/A</p> <p>Effective Date: Immediately</p>
2. Preparticipation Physical Evaluation (Sports Medicine Advisory Committee) Attachment P2	Approve the Preparticipation Physical Evaluation Monograph, 5 th Edition.	<p>Rationale: 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>Budget Impact: N/A</p> <p>Educational Impact: N/A</p> <p>Equity Impact: N/A</p> <p>Effective Date: 2021-22 School Year</p>

AGENDA ITEM

3. Transfer Policy

Discuss the current Transfer Policy relative to “athletic purposes.”

Rationale: 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.

Budget Impact: N/A

Educational Impact: N/A

Equity Impact: N/A

Effective Date: N/A

4. Academic Requirements

Discuss State Board Policy relative to the second semester eligibility.

Rationale: 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.

Budget Impact: N/A

Educational Impact: N/A

Equity Impact: N/A

Effective Date: N/A

5. Event Security

Discuss policies and procedure relative to required law enforcement at contest. NCHSAA Handbook 2.5.3(a)

Rationale: 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.

Budget Impact: N/A

Educational Impact: N/A

Equity Impact: N/A

Effective Date: N/A

6. Lighting Standards
Attachment P3

Discuss the implementation of checklist approval.

Rationale: The checklist is recommended for 2020-21 and required for 2021-22.

Budget Impact: N/A

Educational Impact: N/A

Equity Impact: N/A

Effective Date: N/A

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

Circumstances may arise when there is no LHCP or first responder readily available to supervise a student-athlete's Concussion Return to Play (RTP) Protocol (in-person). In those instances, the NCHSAA Virtually Monitored Concussion RTP V-Monitored Concussion RTP Protocol offers a reasonable alternative to ensure safe progression of a student-athlete through the concussion RTP 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 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.

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.		<input type="checkbox"/> YES	DATE _____ <input type="checkbox"/> YES In-Person Monitored
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. <u>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.</u>		<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 (e.g. 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 (e.g. 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

ATHLETE NAME: _____ DOB: _____ DATE: _____ TIME: _____

DATE: _____ TIME: _____ MONITORED BY: _____ (circle one) MD/DO LAT PA NP

- ☐ 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.



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 **RETURN TO PLAY FORM: Concussion Medical Clearance Releasing the Student-Athlete to Resume Full Participation in Athletics** is completed and kept on file with a copy provided to the student-athlete's parent/legal custodian.



**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 5th 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"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) 		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> Pupils equal Hearing 		
Lymph nodes		
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) 		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis 		
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"> Double-leg squat test, single-leg squat test, and box drop or step drop test 		

^a 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 ≥ 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?			

BONE AND JOINT QUESTIONS		Yes	No
14.	Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15.	Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS		Yes	No
16.	Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17.	Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18.	Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19.	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?		
20.	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21.	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22.	Have you ever become ill while exercising in the heat?		
23.	Do you or does someone in your family have sickle cell trait or disease?		
24.	Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (CONTINUED)		Yes	No
25.	Do you worry about your weight?		
26.	Are you trying to or has anyone recommended that you gain or lose weight?		
27.	Are you on a special diet or do you avoid certain types of foods or food groups?		
28.	Have you ever had an eating disorder?		
FEMALES ONLY		Yes	No
29.	Have you ever had a menstrual period?		
30.	How old were you when you had your first menstrual period?		
31.	When was your most recent menstrual period?		
32.	How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

This image shows a single sheet of white paper with horizontal blue ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

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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
WARNING! Turn off electricity at power source and at safety disconnect on poles	Lighting Performance Testing				
	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				
	Service Entrance, Poles, and Distribution Boxes				
	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.				
	Pole Structures				
	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				
	Luminaires				
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

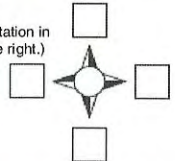
Date of Readings: _____ By: _____
 School Name: _____ Seating Capacity: _____
 School Contact: _____
 Telephone: _____ Email: _____
 Facility Name: _____
 Facility Address: _____ City, State, Zip: _____

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

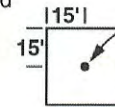
Field Orientation:
 (Please indicate field orientation in cells around diagram to the right.)



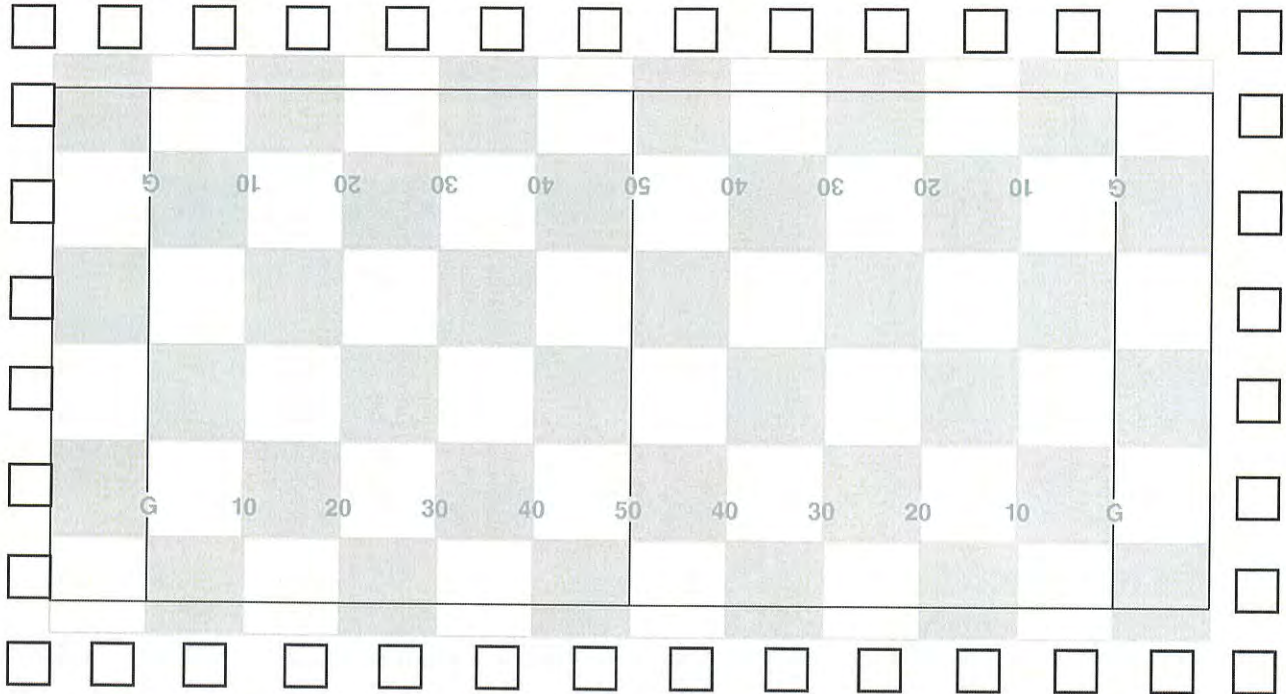
This form will automatically calculate light levels and uniformities if used electronically.

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

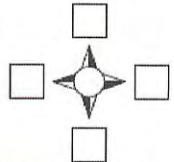
Date of Readings: _____ By: _____
 School Name: _____ Seating Capacity: _____
 School Contact: _____
 Telephone: _____ Email: _____
 Facility Name: _____
 Facility Address: _____ City, State, Zip: _____

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

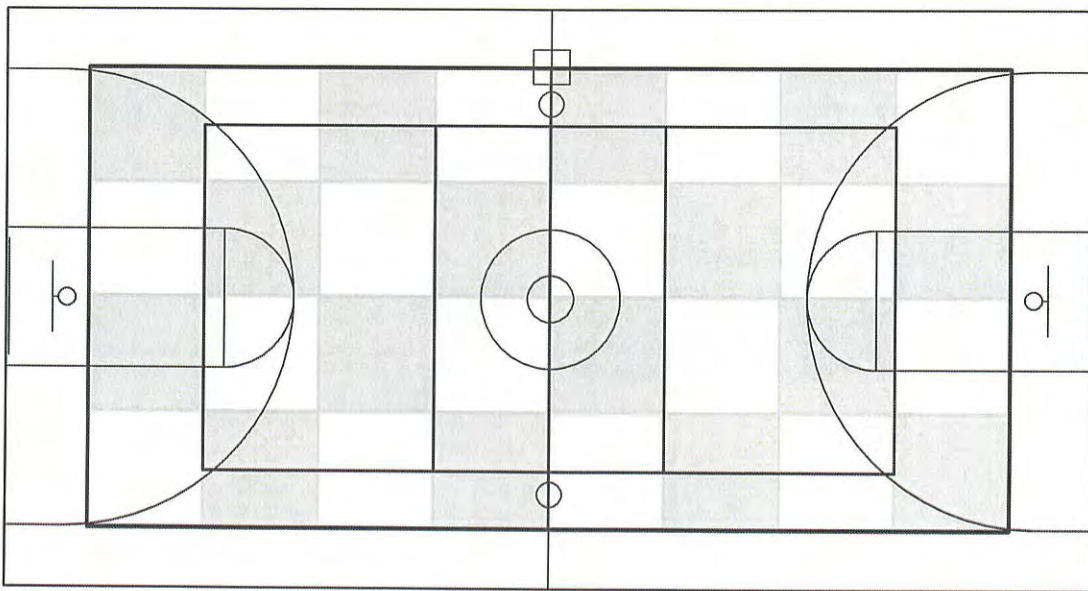
This form will automatically calculate light levels and uniformities if used electronically.

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.)



10' x 10' grid Readings taken in center of grid area.



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: _____