Dear CVA student-athlete parent/guardian,

This letter is to inform you of the health paperwork requirements for participation at CVA. We send an electronic copy of this packet in June and the hard copy version again in July to ensure your receipt. We utilize an injury tracking software called SportsWare that is HIPAA compliant and safe to use. Please see the specific instructions below regarding **required** paperwork in order to participate. See attached instructions for using Sportsware and XLNTbrain. Entire checklist to be completed by August 1st, 2018 for fall term and October 1st, 2018 for winter term.

TO COMPLETE ONLINE

- ❑ TB form (Sportsware)
- ❑ OTC (Sportsware)
- ❑ Concussion Acknowledgement (Sportsware)
- ❑ Athlete profile to include Name, USSA ID, class, gender, DOB, insurance info (Sportsware)
- ❑ XLNTbrain concussion baseline test done annually (XLNTbrain)

  ***New students - see XLNTbrain Instructions pg 10**

  ***Returning students - do not create a new account. Log-in to your existing account after July 15th to complete baseline test.**

HARD COPY INCLUDED TO BE COMPLETED AND RECEIVED BY August 1st (fall term) October 1st (winter term)

- ❑ Physical (dated after 6/26/17 for fall term and after 8/28/17 for winter term or 14 months prior to start date)
- ❑ Informed consent
- ❑ Family Hx (if not already on file)
- ❑ 2 page Medical Emergency General Information and Treatment/Emergency Consent form with copy of insurance card attached
- ❑ Immunizations or Exemption Form (if not already on file)

SPECIAL CIRCUMSTANCES ONLY AS IT APPLIES (also found on Sportsware)

- 18+ form (for students over 18)
- Asthma Plan (completed by physician) http://www.maine.gov/dhhs/mecdc/population-health/mat/documents/2010-action-plan.pdf
- Allergy Form (completed by physician) http://www.foodallergy.org/file/emergency-care-plan.pdf
- Permission for Prescription form (completed by physician)

REQUIRED READING IN HANDOUTS SECTION OF SPORTSWARE

- CDC concussion handout parents
- CDC concussion handout athlete
- Wellness service
- Parent Expectations
- Concussion Policy Overview
- Sudden Cardiac Arrest
- Athlete Eating Guide
- Environmental Considerations
- A copy of this letter
- XLNTbrain Concussion baseline testing instructions

Please keep in mind that if your athlete had an injury requiring a doctor's visit since the last physical, we will need a clearance note from a physician.

Incomplete paperwork or failure to complete the concussion baseline test annually will result in the athlete not being cleared to participate so thank you for making this process smooth so that your child will be able to start training right away when arriving at CVA. Please contact us with questions via the email below since we do not hold regular office hours in the summer. Thank you and we look forward to seeing you! Please complete by ***August 1st for fall term and October 1st for winter term***.

Tristy Wolfe MA LAT ATC CA and Amy Martin RN
Athletic Trainer and School Nurse
wellness@gocva.com

Medical Emergency General Information

To be completed by parent(s) or guardian unless over the age of 18
A student will not be permitted to participate in athletics or start school/camp
until all the forms are complete and returned to Carrabassett Valley Academy (CVA)

Students/Camper Name _____
Last First Middle

Date of Birth _____/_____/_____ Student/Camper Cell Phone _____

Home Address _____
Street City State Zip

Emergency Contacts Student Resides with: ___Both Parents ___Mother ___Father

Other(please specify contact information): _____

Mother (Name) _____ Father (Name) _____

Home Phone (_____) _____ Home Phone (_____) _____

Work Phone (_____) _____ Work Phone (_____) _____

Cell (_____) _____ Cell (_____) _____

E-Mail _____ E-Mail _____

Alternate Emergency Contact: (Name)_____

Relationship:_____Home/Cell Phone: (____)_____ Work Phone (____)_____

Current Medications:_____

_____

Please list relevant medical conditions/history:

_____

_____

_____

History of concussions with dates:_____

_____

Allergies (Please note if EPIPEN is prescribed and ensure athlete carries epipen at all times):

_____

If student/camper has been diagnosed with Asthma and/or Severe Allergies and self carries a rescue inhaler or Epi-pen, please print the Maine Asthma Action plan or Allergy Plan and have health care provider complete it before coming to school/camp.

Asthma Plan: http://www.maine.gov/dhhs/mecdc/population-health/mat/documents/2010-action-plan.pdf

Use for all allergies: http://www.foodallergy.org/file/emergency-care-plan.pdf

Medical Acknowledgement/Treatment and Emergency Consent

Student/Camper Name_____ Date of Birth _____/_____/_____

I hereby give consent for Carrabassett Valley Academy Health Care Providers (The Nurse and Athletic Trainer) or other Health Care Providers considered appropriate by them, to carry out accepted procedures for diagnosis, minor medical treatment, minor surgical treatment and in-school counseling within the scope of their licenses and certifications for my son/daughter- unless I specify otherwise in the comments space provided below.

In the event of emergency in which time is an important factor and CVA personnel are unable to contact me or an alternate Emergency Contact, I authorize CVA Health Care Providers, School/Camp Officials, Coaches during athletic travel and competitions, and Teachers in charge, during field trips, to exercise their best judgment, and hereby authorize them to approve necessary and urgent medical or surgical treatment and/or hospitalization in the interest of my son's/daughter's welfare.

I also give permission for medical information provided by me to CVA to be released to CVA Health Care Providers, and at their discretion to CVA Faculty on a limited need-to-know basis, as well as to other appropriate Health Care Providers who may need this information in order to treat my son/daughter in a medical emergency.

By signing below, I certify that I have provided information on medical conditions relevant to safe participation and medical treatment as needed. I also understand that CVA follows the USSA and USASA guidelines regarding concussion including removal of athlete from participation and a required doctor's note for return. I realize that my athlete may not participate without providing a **physical signed by a physician within the last two years (camper) or 14 months (student) and that if I am under treatment, I will not participate until I am discharged from treatment, or am given permission by the treating practitioner to restart participation despite continuing treatment.** I acknowledge that CVA has the right to require a doctor's clearance based on injuries occurring after the last physical.

UNLESS A DAY CAMPER: include a copy of your immunization records and attach insurance card below. If the athlete is on prescription medication, please contact Amy the nurse at 207-237-4489 prior to arrival. **UNLESS A CAMPER:** By signing below, I acknowledge that I have read all the information in the handouts section of Sportsware. I acknowledge that CVA will be providing blinded injury data with no identification information for injury surveillance research to USSA.

Front of Card Back of Card

Comments:

_____/_____/_____ _____

Today's Date Parent/Guardian Signature

Health Care Provider
Informed Consent and Consent for Treatment

Student/Camper: _____Student/Camper Date of Birth ____/_____/_____

_____ _____ _____

Signature of Patient or Parent/Guardian | Your Initials | Relationship | Date

1. Privacy Practices do not allow Health Care Providers to share your Child's Medical Information with anyone without your written permission. Please check only one box below.

☐ I give permission to share my child's medical information with the nurse or athletic trainer at Carrabassett Valley Academy (CVA) for continuity of care. They may share that information with other CVA staff members on a need to know basis.

☐ DO NOT share my child's medical information with anyone other than me or my spouse.

Initials of Parent or Guardian

2. Acknowledgement of right to cancel consent to release medical information:
I understand that I can cancel my consent at any time before the release of information by completing a "revocation form" available at the Providers Office. A decision to remove my consent may cause denial of health benefits or insurance coverage due to lack of review information from my chart. I can refuse to disclose some or all of my records, but if I do so, it could result in an improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences. Partial or incomplete records will be labeled as such to inform the provider receiving them of their status. I am entitled to a copy of this authorization form. This authorization is good for 30 months.

Initials of Parent or Guardian

Consent for Treatment with any Health Care Provider:

1. I hereby authorize the medical staff of your medical facility to perform diagnostic procedures as may be determined to be needed for the diagnosis of the condition or conditions for which treatment is sought by me and to treat said condition.
2. I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me as the result of treatment or examination in your Medical facility
3. I authorize your medical facility and its employees to use the information contained in my record for proper medical purposes, for use in-patient care evaluation studies or for studies of department work performance with identifiers removed.
4. I hereby authorize the medical staff of your medical facility: (i) to perform any diagnostic procedures necessary for the diagnosis of the condition(s) for which I am seeking treatment; (ii) To treat the condition(s) for which I am seeking treatment; and (iii) to perform any necessary procedures or otherwise administer any necessary forms of treatment. It is my intention that this consent shall be standing consent for my diagnosis and treatment in the event of any subsequent visits to your medical facility, until specifically revoked.

Initials of Parent or Guardian

Payment of Benefits and Information Release:
I request that payment of authorized insurance benefits be made on my behalf to the medical facility for any services furnished to me by the medical facility. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable to related services. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered by the medical facility.

Initials of Parent or Guardian

This release will be utilized for but not limited to: 1) The Mt Abram Health Center 2) Rangeley Region Health Center 3) Franklin Orthopaedics 4) Franklin Memorial Hospital 5) Sandy River Podiatry 6) Oral/Facial Surgery 7) Western Mountain Chiropractic 8) Allied Physical Therapy 9) Equinox Therapeutic Massage 10) HealthQuest Chiropractic. If you would like to limit the use, please cross off the provider listed above, understanding it will slow CVA's ability to get prompt medical care, unless it is an emergency situation.

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

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

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

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

_____

_____

_____

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

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

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

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

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

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

☐ Cleared for all sports without restriction

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

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

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

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

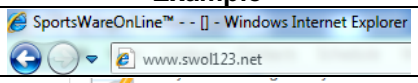
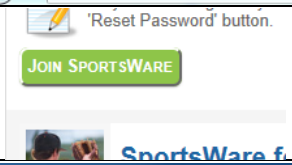
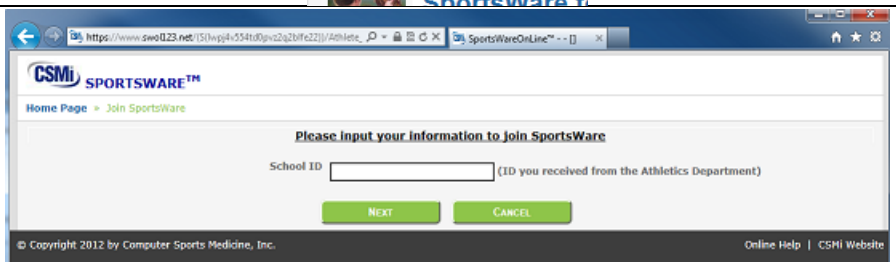
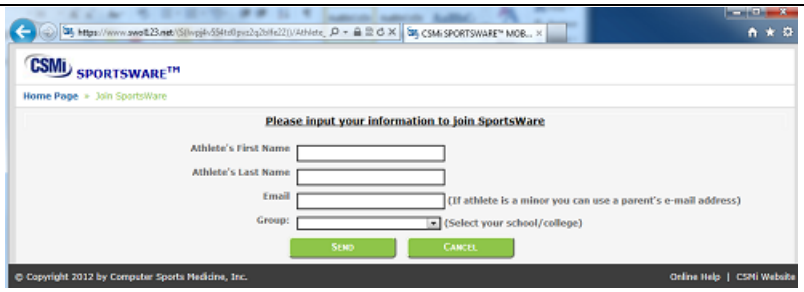
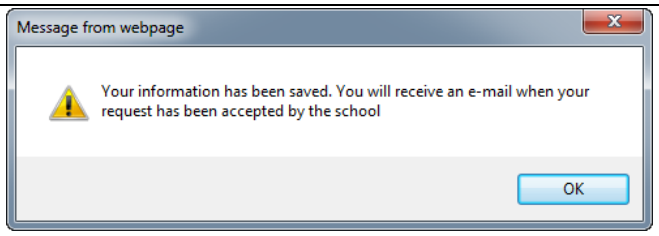
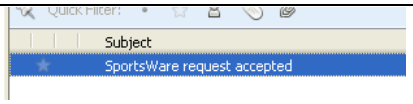
Signature of physician _____, MD or DO

Dear parent/guardian of CVA athlete:

Prior to participating at CVA, athletes must provide the Wellness Team with current address, insurance, USSA ID, gender, date of birth and other required documentation. To expedite this process CVA uses an online data entry system. **This must be completed by the parent/guardian**.

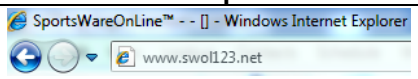
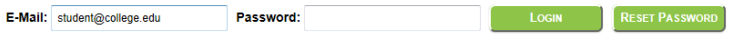
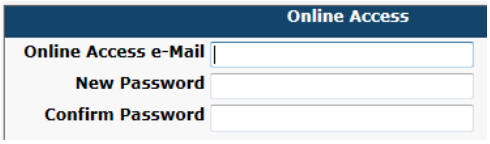
To enter your information, visit www.swol123.net and follow instructions below. If you are already a member, log in with your email address and password you originally used (use forgot password as needed).

Joining SportsWareOnLine

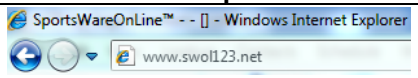
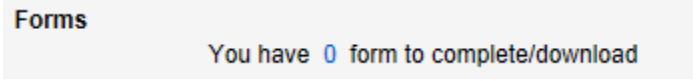
Instruction	Example
Go to www.swol123.net.	
Scroll to the middle of the screen and click the **Join SportsWare** button.	
Enter your School ID **BigDogs** *You should have received a School ID from the athletic trainer. This is required to join the correct school.*	
Enter your First Name, Last Name, Email address and click the Send button.	
Your request to join SportsWare will then be sent to the Athletic Trainer/Nurse for review and may take a few days.	
Once your request is accepted you will receive an e-mail with the Subject *"SportsWare request accepted".*	

Open the e-mail and click the www.swol123.net link to continue to SportsWareOnLine.	

Setting Your Password

Instruction	Example
Go to www.swol123.net	
Enter your Email Address and click the **Reset Password** button.	
You will receive an e-mail with the Subject *"SportsWareOnLine Password Request"*. Open the e-mail and click on the link to reset your password. Enter your e-mail address, new password and click the **Save** button.	

Updating Your Information

Instruction	Example
Go to www.swol123.net	
Enter your Email Address and password and click the **Login** button.	
At the top of the page is the Menu Bar. **My Info:** Update your address, DOB, gender, USSA ID and insurance information. **Forms:** View/complete required paperwork. Note: SportsWare will also display "*You have 7 forms to complete/download"*. Click the number or forms to begin.	 

Join Carrabassett Valley Academy on XLNTbrain

Carrabassett Valley Academy has joined XLNTbrain in the fight against concussion injury in sports.

Concussion awareness education is mandated by State law for all athletes and their parents and / or guardians. This document outlines the steps required for athletes, parents and / or guardians to register at XLNTbrain.com.

The XLNTbrain Passcode for Carrabassett Valley Academy is: **CARRABASSETT VALLEY ACADEMY ATHLETE**

We recommend the web browser Mozilla FireFox for PC and Mac users.

Athlete Registration

Go to XLNTbrain.com, click "Sign Up" and enter the passcode above to begin your registration. Click "Join as an Athlete" after you complete your registration,and then follow these steps:

1. View concussion awareness video and pass brief video quiz
2. Update profile info & accept terms and conditions
3. Manage your teams
4. Take the XLNTbrain Baseline Test

The XLNTbrain Baseline Test takes approximately 25 minutes and is important for your healthcare provider to use as a baseline to compare for your recovery. It is important for you to take the test seriously and be in an environment free of distractions as you test. If you perform poorly on the test, you may be asked to repeat the test under supervision.

XLNTbrain Baseline Test Quick Guide

Please sign into your account on http://app.xlntbrain.com/. Once you ve signed in, click the link near the top of your screen that asks if you want to take the test now. You will need Microsoft Silverlight installed and updated on your computer to run the test. Silverlight is not supported by Windows XP with any browser. Edge, Internet Explorer 11 or Chrome are also not supported in any operating system. The page will display an error message if you are using an unsupported browser. It s best to use the Firefox web browser when installing Silverlight. Use the following URL to install Firefox https://www.mozilla.org/en-US/firefox/new/. Once Silverlight is installed and updated, please start the test by selecting the Click here to Start your Cog Test button.

Please keep in mind that the XLNTbrain-Cog test is for Athletes only.

If this is not your first year with us, it is likely you have the XLNTbrain-Cog Test already installed on your machine. You ll need to uninstall the cog test application and you can find detailed instructions at http://app.xlntbrain.com/cog_test_faq.

Guardian Registration

Go to XLNTbrain.com, and enter the passcode above to begin your registration. Click "Join as a Guardian" after you complete your registration. With your ï¬rst-time sign-in, you will view a short concussion awareness video. After reviewing the video and passing a brief video quiz, you will need to add your athlete as a dependent. Then you will be able to access your athlete's profile, where you may monitor the progress of your athlete within XLNTbrain.

To add your Dependent, please look on the left hand side of your Dashboard you should see a tab called "Relationships". Click on that tab and then click "Add Dependent". You will need to enter your Athlete's XLNT Brain ID in the box. If you enter your Athlete's name it will not work. Your Athlete's XLNT ID is listed on their account when they are logged on, in the upper right hand corner. It will look like this: XLNTbrain ID : ZWE2NDU4M, except with your Athlete's ID of course. Once you enter your Athlete's XLNT ID, click the Add Dependent button and that should link your accounts. You may need to refresh your page or log out of your dashboard and log back in to update the information your dashboard shows.

XLNTbrain Help

Click on the "Help" button at any time to ask for help. Please note this is not a Live Chat. However a support representative will respond to your request as soon as possible.