

## Middle School Sports

Dear Athletes and Parents:

Attached are the **MIAA Part A-B form, Concussion, and Opioid use & misuse information**. All forms that require signatures need to be completed for your child to participate in any school sport. To prevent delays, please follow and complete these guidelines before try-outs:

1. Answer **ALL** questions on the MIAA Part A form. **Sign and date the MIAA Part A (two signatures required Parent and Athlete)** If you note "Yes" for any numbers on the Part A of the MIAA form, please explain fully on the blank lines on the lower left and/or have your doctor review and comment.
2. **Physicals need to be less than 13 months old AND on file with the school nurse.** Many doctor's offices will not fax physicals, so please plan to pick them up from their office. Please allow 48-72 hours for your doctor's office to have a copy for you. **If the athlete's physical expires during the sports season, SCHEDULE ONE NOW. Athletes are not allowed to complete the season without a current physical.**
3. Be certain that your doctor/nurse practitioner/physician's assistant indicates **clearance for participation in sports on the current physical.** Office visit notes do not count as physicals.
4. Include a clearance (return to play) note from a physician if there has been a recent injury, fracture, concussion, surgery, lengthy illness etc.
5. **Medication orders** for emergency treatments (epi-pens, inhalers and diabetes) are required **PRIOR** to clearing students by the school nurse to participate in sport.
6. Please allow a full school day for medical clearance from the school nurse (Plan accordingly and don't wait to turn paperwork into the school nurse on day one of try-outs, you won't be able to try out that day)
7. Review **Opioid use and misuse information & Concussion packet (attached)**
8. Additionally complete the **Pre-Participation Head Injury** and the **bottom of this form**, by both athlete and parent AND return to school nurse.

Thank You, School Nurse(s)

I have received and reviewed Opioid use and misuse information. Date: \_\_\_\_\_

I have received and reviewed Heads UP concussion information. Date: \_\_\_\_\_

Athlete Name (Printed) \_\_\_\_\_ Signature: \_\_\_\_\_

Parent Name (Printed) \_\_\_\_\_ Signature: \_\_\_\_\_





The Commonwealth of Massachusetts  
 Executive Office of Health and Human Services  
 Department of Public Health  
 250 Washington Street, Boston, MA 02108-4619

DEVAL L. PATRICK  
 GOVERNOR

TIMOTHY P. MURRAY  
 LIEUTENANT GOVERNOR

JUDYANN BIGBY, MD  
 SECRETARY

JOHN AUERBACH  
 COMMISSIONER

**PRE-PARTICIPATION HEAD  
 INJURY/CONCUSSION REPORTING FORM  
 FOR EXTRACURRICULAR ACTIVITIES**

This form should be completed by the student's parent(s) or legal guardian(s). It must be submitted to the Athletic Director, or official designated by the school, *prior* to the start of each season a student plans to participate in an extracurricular athletic activity.

Student's Name	Sex	Date of Birth	Grade
School		Sport(s)	
Home Address			Telephone

Has student ever experienced a traumatic head injury (a blow to the head)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when? Dates (month/year): \_\_\_\_\_

Has student ever received medical attention for a head injury? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when? Dates (month/year): \_\_\_\_\_

If yes, please describe the circumstances:

Was student diagnosed with a concussion? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when? Dates (month/year): \_\_\_\_\_

Duration of Symptoms (such as *headache, difficulty concentrating, fatigue*) for most recent concussion: \_\_\_\_\_

Parent/Guardian:  
 Name: \_\_\_\_\_ Signature/Date \_\_\_\_\_  
 (Please print)

Student Athlete:  
 Signature/Date \_\_\_\_\_



# MIAA RECOMMENDED SPORTS CANDIDATE MEDICAL QUESTIONNAIRE



(Reference MIAA Rule 56)

## PART A ~ HISTORY

DATE of EXAM \_\_\_\_\_

Student's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

Address \_\_\_\_\_ Tel \_\_\_\_\_

Physician \_\_\_\_\_ Tel \_\_\_\_\_

**IN CASE OF AN EMERGENCY, CONTACT:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Tel (H) \_\_\_\_\_ (W) \_\_\_\_\_

**EXPLAIN "YES" ANSWERS BELOW. CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWERS TO.**

- |  | YES                   | NO                    |   | YES                              | NO                                 |
|--|-----------------------|-----------------------|---|----------------------------------|------------------------------------|
| 1. Have you had a medical illness or injury since your last check up or sports physical?                                     | <input type="radio"/> | <input type="radio"/> | 30. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | <input type="radio"/>            | <input type="radio"/>              |
| 2. Have you ever been hospitalized overnight?  | <input type="radio"/> | <input type="radio"/> | 31. Have you had any problems with your eyes or vision?   | <input type="radio"/>            | <input type="radio"/>              |
| 3. Have you ever had surgery?  | <input type="radio"/> | <input type="radio"/> | 32. Do you wear glasses, contacts, or protective eyewear?   | <input type="radio"/>            | <input type="radio"/>              |
| 4. Do you have a missing or diseased paired organ?   | <input type="radio"/> | <input type="radio"/> | 33. Have you ever had a sprain, strain, or swelling after injury?   | <input type="radio"/>            | <input type="radio"/>              |
| 5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler? | <input type="radio"/> | <input type="radio"/> | 34. Have you broken or fractured any bones or dislocated any joints?  | <input type="radio"/>            | <input type="radio"/>              |
| 6. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?              | <input type="radio"/> | <input type="radio"/> | 35. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?  | <input type="radio"/>            | <input type="radio"/>              |
| 7. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?                                  | <input type="radio"/> | <input type="radio"/> | <i>If yes, check appropriate box and explain below:</i>   |                                  |                                    |
| 8. Have you ever had a rash or hives develop during or after exercise?   | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> Head   | <input type="checkbox"/> Elbow   | <input type="checkbox"/> Hip       |
| 9. Have you ever passed out during or after exercise?  | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> Neck   | <input type="checkbox"/> Forearm | <input type="checkbox"/> Thigh     |
| 10. Have you ever been dizzy during or after exercise?   | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> Back   | <input type="checkbox"/> Wrist   | <input type="checkbox"/> Knee      |
| 11. Have you ever had chest pain during or after exercise?   | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> Chest  | <input type="checkbox"/> Hand    | <input type="checkbox"/> Shin/Calf |
| 12. Do you get tired more quickly than your friends do during exercise?  | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> Shoulder   | <input type="checkbox"/> Finger  | <input type="checkbox"/> Ankle     |
| 13. Have you ever had racing of your heart or skipped heartbeat?   | <input type="radio"/> | <input type="radio"/> | <input type="checkbox"/> Upper Arm  | <input type="checkbox"/> Foot    |                                    |
| 14. Have you had high blood pressure or high cholesterol?  | <input type="radio"/> | <input type="radio"/> | 36. Do you want to weigh more or less than you do now?  | <input type="radio"/>            | <input type="radio"/>              |
| 15. Have you ever been told you have a heart murmur?   | <input type="radio"/> | <input type="radio"/> | 37. Do you lose weight regularly to meet weight requirements for your sport?  | <input type="radio"/>            | <input type="radio"/>              |
| 16. Has any family member or relative died of heart problems or of sudden death before age 50?                               | <input type="radio"/> | <input type="radio"/> | 38. Do you feel stressed out?   | <input type="radio"/>            | <input type="radio"/>              |
| 17. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?                 | <input type="radio"/> | <input type="radio"/> | 39. Record the dates of your most recent immunizations (shots) for:   |                                  |                                    |
| 18. Has a physician ever denied or restricted your participation in sports for any heart problems?                           | <input type="radio"/> | <input type="radio"/> | Tetanus _____   | Measles _____                    |                                    |
| 19. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?                  | <input type="radio"/> | <input type="radio"/> | Hepatitis B _____   | Chickenpox _____                 |                                    |
| 20. Have you ever had a head injury or concussion?   | <input type="radio"/> | <input type="radio"/> | <b>FEMALES ONLY:</b>  |                                  |                                    |
| 21. Have you ever been knocked out, become unconscious, or lost your memory?   | <input type="radio"/> | <input type="radio"/> | 40. When was your first menstrual period? _____   |                                  |                                    |
| 22. Have you ever had a seizure?   | <input type="radio"/> | <input type="radio"/> | 41. When was your most recent menstrual period? _____   |                                  |                                    |
| 23. Do you have frequent or severe headaches?  | <input type="radio"/> | <input type="radio"/> | 42. How much time do you usually have from the start of one period to the start of another? _____   |                                  |                                    |
| 24. Have you ever had numbness or tingling in your arms, hands, legs, or feet?   | <input type="radio"/> | <input type="radio"/> | 43. How many periods have you had in the last year? _____   |                                  |                                    |
| 25. Have you ever had a slinger, burner, or pinched nerve?   | <input type="radio"/> | <input type="radio"/> | 44. What was the longest time between periods in the last year? _____   |                                  |                                    |
| 26. Have you ever become ill from exercising in the heat?  | <input type="radio"/> | <input type="radio"/> | <i>Explain "Yes" answers here:</i>  |                                  |                                    |
| 27. Do you cough, wheeze, or have trouble breathing during or after activity?  | <input type="radio"/> | <input type="radio"/> | _____   |                                  |                                    |
| 28. Do you have asthma?  | <input type="radio"/> | <input type="radio"/> | _____   |                                  |                                    |
| 29. Do you have seasonal allergies that require medical treatment?   | <input type="radio"/> | <input type="radio"/> | _____   |                                  |                                    |

**I HEREBY STATE THAT TO THE BEST OF MY KNOWLEDGE, MY ANSWERS TO THE ABOVE QUESTIONS ARE COMPLETE AND CORRECT.**

Signature of Athlete/Date \_\_\_\_\_ Signature of Parent-Guardian/Date \_\_\_\_\_

(continued)

Revised 6/17/13



**PART B ~ PHYSICAL EXAMINATION**



DATE of EXAM \_\_\_\_\_

STUDENT (Please print) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body Fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ / \_\_\_\_\_ ( \_\_\_\_\_ / \_\_\_\_\_ , \_\_\_\_\_ / \_\_\_\_\_ )

Eyes: R20/ \_\_\_\_\_ L20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*\*Station-based examination only*

**PART C ~ CLEARANCE**

- Cleared
- Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- Not cleared for: \_\_\_\_\_ Reason: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DATE of EXAM \_\_\_\_\_

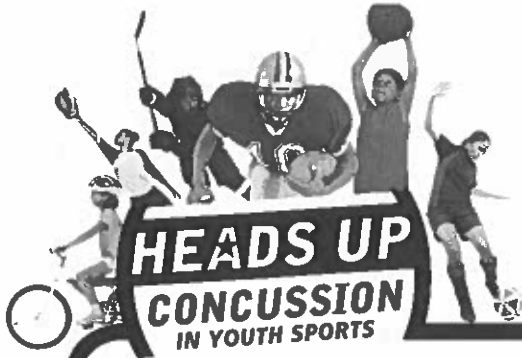
Name of physician (Please print): \_\_\_\_\_

Signature of physician: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Tel: \_\_\_\_\_







## A Fact Sheet for PARENTS

### WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury. Concussions are caused by a bump or blow to the head. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

You can’t see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

### WHAT ARE THE SIGNS AND SYMPTOMS OF A CONCUSSION?

#### Signs Observed by Parents or Guardians

*If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs and symptoms of a concussion:*

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes

#### Symptoms Reported by Athlete

- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just “not feeling right” or “feeling down”

### HOW CAN YOU HELP YOUR CHILD PREVENT A CONCUSSION OR OTHER SERIOUS BRAIN INJURY?

- Ensure that they follow their coach’s rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.
- Make sure they wear the right protective equipment for their activity. Protective equipment should fit properly and be well maintained.
- Wearing a helmet is a must to reduce the risk of a serious brain injury or skull fracture.
  - However, helmets are not designed to prevent concussions. There is no “concussion-proof” helmet. So, even with a helmet, it is important for kids and teens to avoid hits to the head.

### WHAT SHOULD YOU DO IF YOU THINK YOUR CHILD HAS A CONCUSSION?

#### 1. SEEK MEDICAL ATTENTION RIGHT AWAY.

A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to regular activities, including sports.

#### 2. KEEP YOUR CHILD OUT OF PLAY.

Concussions take time to heal. Don’t let your child return to play the day of the injury and until a health care professional says it’s OK. Children who return to play too soon—while the brain is still healing—risk a greater chance of having a repeat concussion. Repeat or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.

#### 3. TELL YOUR CHILD’S COACH ABOUT ANY PREVIOUS CONCUSSION.

Coaches should know if your child had a previous concussion. Your child’s coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

*It’s better to miss one game than the whole season.*

For more information, visit [www.cdc.gov/Concussion](http://www.cdc.gov/Concussion).



## Hoja Informativa para los PADRES

### ¿QUÉ ES LA CONMOCIÓN CEREBRAL?

Una conmoción cerebral es una lesión en el cerebro, causada por un golpe en la cabeza o una sacudida. Incluso una pequeña conmoción o lo que parece ser un golpe o sacudida leve puede ser serio.

La conmoción cerebral no puede verse. Los signos y síntomas de una conmoción pueden aparecer inmediatamente después de la lesión o puede que no aparezcan, o se hagan visibles algunos días o meses después de haber sufrido la lesión. Si su hijo tiene los signos de una conmoción cerebral o si usted nota algún síntoma, busque atención médica de inmediato.

### ¿CUÁLES SON LOS SIGNOS Y SÍNTOMAS DE LA CONMOCIÓN CEREBRAL?

#### Signos que notan los padres y los tutores

*Si su hijo ha sufrido un golpe en la cabeza o una sacudida durante un juego o una práctica, obsérvelo para determinar si tiene alguno de los siguientes signos y síntomas de una conmoción cerebral:*

- Luce aturdido o fuera de control
- Se confunde con la actividad asignada
- Olvida las jugadas
- No se muestra seguro del juego, la puntuación ni de sus adversarios
- Se mueve con torpeza
- Responde con lentitud
- Pierde el conocimiento (así sea momentáneamente)
- Muestra cambios de conducta o de personalidad
- No puede recordar lo ocurrido antes de un lanzamiento o un caída
- No puede recordar lo ocurrido después de un lanzamiento o un caída

#### Síntomas que reporta el atleta

- Dolor o "presión" en la cabeza
- Náuseas o vómitos
- Problemas de equilibrio, mareo
- Visión doble o borrosa
- Sensibilidad a la luz y al ruido
- Se siente débil, confuso, aturdido o grogui
- Problemas de concentración o memoria
- Confusión
- No se "siente bien"

### ¿CÓMO AYUDAR A SU HIJO A PREVENIR UNA CONMOCIÓN CEREBRAL?

Aunque todo deporte es diferente, hay medidas que puede tomar para protegerse.

- Haga que siga las reglas impartidas por el entrenador y las reglas del deporte que practica.
- Invítelo a mantener el espíritu deportivo en todo momento.
- Haga que su hijo use el equipo protector adecuado según la actividad que realiza. El equipo de protección debe ajustarse bien, debe hacerse el mantenimiento adecuado, y el jugador debe usarlo correctamente y en todo momento.

### ¿QUÉ DEBE HACER SI CREE QUE SU HIJO HA SUFRIDO UNA CONMOCIÓN CEREBRAL?

- 1. Busque atención médica de inmediato.** Un profesional de la salud podrá determinar la seriedad de la conmoción cerebral que ha sufrido el niño y cuándo podrá regresar al juego sin riesgo alguno.
- 2. No permita que su hijo siga jugando.** Las conmociones cerebrales necesitan de un cierto tiempo para curarse. No permita que su hijo regrese al juego hasta que un profesional de la salud le haya dicho que puede hacerlo. Los niños que regresan al juego antes de lo debido—mientras el cerebro está en proceso de curación—corren un mayor riesgo de sufrir otra conmoción. Las conmociones cerebrales siguientes pueden ser muy serias. Pueden causar daño cerebral permanente que afectarán al niño de por vida.
- 3. Informe al entrenador del niño sobre cualquier conmoción cerebral que el niño haya sufrido recientemente.** Los entrenadores deben saber si el niño ha sufrido una conmoción recientemente en CUALQUIER deporte. El entrenador no necesariamente sabrá si el niño ha tenido una conmoción en otro deporte o actividad a menos que usted se lo diga.

***Es preferible perderse un juego que toda la temporada.***

Para obtener más información, visite [www.cdc.gov/ConcussionInYouthSports](http://www.cdc.gov/ConcussionInYouthSports).

# HEADS+UP

## CONCUSSION IN HIGH SCHOOL SPORTS

A FACT SHEET FOR **ATHLETES**

### Concussion facts:

- A concussion is a brain injury that affects how your brain works.
- A concussion is caused by a bump, blow, or jolt to the head or body.
- A concussion can happen even if you haven't been knocked out.
- If you think you have a concussion, you should not return to play on the day of the injury and not until a health care professional says you are OK to return to play.

### What are the symptoms of a concussion?

Concussion symptoms differ with each person and with each injury, and they may not be noticeable for hours or days. Common symptoms include:

- Headache
- Confusion
- Difficulty remembering or paying attention
- Balance problems or dizziness
- Feeling sluggish, hazy, foggy, or groggy
- Feeling irritable, more emotional, or "down"
- Nausea or vomiting
- Bothered by light or noise
- Double or blurry vision
- Slowed reaction time
- Sleep problems
- Loss of consciousness

During recovery, exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse.

### What should I do if I think I have a concussion?

**DON'T HIDE IT. REPORT IT.** Ignoring your symptoms and trying to "tough it out" often makes symptoms worse. Tell your coach, parent, and athletic trainer if you think you or one of your teammates may have a concussion. Don't let anyone pressure you into continuing to practice or play with a concussion.

**GET CHECKED OUT.** Only a health care professional can tell if you have a concussion and when it's OK to return to play. Sports have injury timeouts and player substitutions so that you can get checked out and the team can perform at its best. The sooner you get checked out, the sooner you may be able to safely return to play.

**TAKE CARE OF YOUR BRAIN.** A concussion can affect your ability to do schoolwork and other activities. Most athletes with a concussion get better and return to sports, but it is important to rest and give your brain time to heal. A repeat concussion that occurs while your brain is still healing can cause long-term problems that may change your life forever.

### How can I help prevent a concussion?

Every sport is different, but there are steps you can take to protect yourself.

- Follow your coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

### If you think you have a concussion:

Don't hide it. Report it. Take time to recover.

**It's better to miss one game than the whole season.**

For more information, visit [www.cdc.gov/Concussion](http://www.cdc.gov/Concussion).





# We are facing an epidemic of opioid addiction and overdose deaths in Massachusetts.

For youth, opioid addiction may start when a clinician prescribes opioids following an injury; through having access to painkillers in the family medicine cabinet; or by borrowing from friends.

Opioids are powerful prescription painkillers. Examples of commonly prescribed opioids include **Oxycontin, Percocet, Vicodin and Fentanyl.**

Although these medications are effective when prescribed and taken appropriately, they can be misused and lead to significant negative consequences, including overdose and addiction. Some people who are addicted may even transition to heroin, which is less expensive and widely available.

## Get More Information

If you suspect your child is having a problem with prescription opioids or heroin, call the **MA Substance Abuse Information and Education Helpline** for free and confidential information about substance abuse, education and counseling resources for adolescents, families and adults.

With your help we can  
**Stop Addiction**  
In Its Tracks

**Contact:**  
**1-800-327-5050**

TTY: Use MassRelay at 711  
or 1-800-439-2370

[www.helpline-online.com](http://www.helpline-online.com)

**Or Visit:**

**[www.mass.gov/stopaddiction](http://www.mass.gov/stopaddiction)**

SA3354/English  
September 2015

Tips for  
Protecting  
Your Kids from  
**Addiction**

**STOP**

**Addiction**

**IN ITS TRACKS**





Some people who are addicted may even transition to heroin, which is less expensive and widely available.

## Parents: Prevent

### Opioid Prescription Abuse

1. **Talk to your teen** and warn them about the potential dangers of taking medications that are not prescribed for them, including addiction and overdose.
2. **Be clear with your expectations** about drug and alcohol use and follow through by supporting healthy decisions that they make.
3. **If your son or daughter needs medications while at school**, request an 8-12 hour dose so you can administer them at home. If medications must be taken during school hours, give them to the school nurse.
4. **Ask your doctor** if any medications prescribed for your family have a potential for abuse.
5. **Take a regular inventory** of medications that are kept in your home that can be abused.
6. **Keep medications in a secure location** away from your children. Consider purchasing a locked box at your local pharmacy to store medications that can be abused.

### Dispose of Unused Prescription Drugs:

- Bring unused medications to secure medication drop off boxes around the state. To find a drop box in your area, visit [www.mass.gov/DrugDropbox](http://www.mass.gov/DrugDropbox).
- Do not flush medicines down the drain unless the label or accompanying patient information specifically instructs you to do so.
- Remove medications from their containers, crush them and mix them with coffee grounds or kitty litter. Place the mixture in an unmarked container, like an empty can or sealable bag, and throw the container in the trash.

## Know the Signs

Many parents are often reluctant to believe that their children may misuse or develop an addiction to prescription opioids. But anyone who experiments with these powerful medications is at risk for negative consequences, including overdose and addiction.

### Signs your child may be abusing or misusing opioids:

- Pills or medication bottles are missing from your home
- Taking medication in excess of how it has been prescribed
- Abrupt changes in their finances
- Dramatic mood changes
- Lower grades, changes in friends, or changes in sleep or appetite
- Loss of concern about appearance
- Physical signs such as fatigue, confusion, weight loss, slurred speech, dizziness and changes in pupil size



