DEUEL SCHOOL DISTRICT 19-4
2017-2018 PHYSICAL INFORMATION

Student/Athletes Name: _____ **Grade in fall:** _____

Dear Parent/Guardian:
Enclosed is important information that you and your child need to read and fill out. **You must have this physical information filled out (front and back) and turned into the Athletic Director before your son/daughter can participate in any athletic activities (including practice) offered by Deuel School.**

TRIENNIAL FORM: If your child has not had a physical or if you mark yes (without explanation) on any of the items on the interim pre-participation agreement your child will need a physical taken before he/she can participate in an athletic activity. **This form does require a Doctors Signature and is to be completed every three years.**

MEDICAL INSURANCE
All students participating in interscholastic activities are required to have medical insurance. (Please check the appropriate box below)

- ☐ We do have family medical insurance (or Medicaid)
- ☐ We do not have family medical insurance and wish to purchase the basic family medical policy

(Athletic Director has insurance applications for school-time and full-time coverage)

SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION
ANNUAL PARENT OR GUARDIAN PERMIT

I hereby give my consent for _____ GRADE _____ ____
Name (Please Print) 2017-18 School Year

who was born at _____ on _____
City, Town, County, State Date of Birth

to compete in SDHSAA approved athletics for the Deuel School District during the 2017-2018 school year.

I/We give our permission for our son/daughter to participate in organized high school athletics, realizing that such activity involves the potential for injury which is inherent in all sports.

Signed _____ Date _____, 20_____
Parent or Legal Guardian

THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL.

SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION
ANNUAL PARENT AND STUDENT CONSENT FORM

School Year: 2017-2018 Name of High School: _____

Name of Student: _____

Date of Birth: _____ Place of Birth: _____

The Parent and Student hereby:

1. Understand and agree that participation in SDHSAA sponsored activities is voluntary on the part of the student and is considered a privilege.

2. Understand and agree that (a) by this Consent Form the SDHSAA has provided notification to the parent and student of the existence of potential dangers associated with athletic participation; (b) participation in any athletic activity may involve injury of some type; (c) the severity of such injuries can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries such as injuries to the body's bones, joints, ligaments, tendons, or muscles. Catastrophic injuries to the head, neck and spinal cord and concussions may also occur. On rare occasions, injuries so severe as to result in total disability, paralysis and death; and (d) even with the best coaching, use of the best protective equipment, and strict observance of rules, injuries are still a possibility.

3. Consent and agree to participation of the student in SDHSAA activities subject to all SDHSAA bylaws and rules interpretations for participation in SDHSAA sponsored activities, and the activities rules of the SDHSAA member school for which the student is participating; and

4. Consent and agree that personally identifiable directory information may be disclosed about the student as a result of his/her participation in SDHSAA sponsored activities. Such directory information may include, but is not limited to, the student's photograph, name, grade level, height, weight, and participation in officially recognized activities and sports. ***If I do not wish to have any or all such information disclosed, I must notify the above mentioned high school, in writing, of our refusal to allow disclosure of any or all such information prior to the student's participation in sponsored activities.***

I acknowledge that I have read paragraphs (1) through (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participating in activities.

DATED this _____ day of _____, 20_____

_____ _____
Name of Student (Print Name) Student Signature

I am the student's parent/guardian. I acknowledge that I have read paragraphs (1) through (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities. I hereby give my permission for _____(student's name) to practice and compete for the above named high school in activities approved by the SDHSAA.

DATED this _____ day of _____, 20_____

_____
Parent/Guardian Signature

SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION
ANNUAL PARENT AND STUDENT CONSENT FORM

School Year: 2017-2018 Name of High School: _____

Name of Student: _____

Date of Birth: _____ Place of Birth: _____

The Parent and Student hereby:

1. Understand and agree that participation in SDHSAA sponsored activities is voluntary on the part of the student and is considered a privilege.
2. Understand and agree that (a) by this Consent Form the SDHSAA has provided notification to the parent and student of the existence of potential dangers associated with athletic participation; (b) participation in any athletic activity may involve injury of some type; (c) the severity of such injuries can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries such as injuries to the body's bones, joints, ligaments, tendons, or muscles. Catastrophic injuries to the head, neck and spinal cord and concussions may also occur. On rare occasions, injuries so severe as to result in total disability, paralysis and death; and (d) even with the best coaching, use of the best protective equipment, and strict observance of rules, injuries are still a possibility.
3. Consent and agree to participation of the student in SDHSAA activities subject to all SDHSAA bylaws and rules interpretations for participation in SDHSAA sponsored activities, and the activities rules of the SDHSAA member school for which the student is participating; and
4. Consent and agree that personally identifiable directory information may be disclosed about the student as a result of his/her participation in SDHSAA sponsored activities. Such directory information may include, but is not limited to, the student's photograph, name, grade level, height, weight, and participation in officially recognized activities and sports. ***If I do not wish to have any or all such information disclosed, I must notify the above mentioned high school, in writing, of our refusal to allow disclosure of any or all such information prior to the student's participation in sponsored activities.***

I acknowledge that I have read paragraphs one (1) through four (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participating in activities.

DATED this _____day of _____, 20_____

_____ _____

Name of Student (Print Name) Student Signature

I am the student's parent/guardian. I acknowledge that I have read paragraphs (1) through (4) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities. I hereby give my permission for _____ (student's name) to practice and compete for the above named high school in activities approved by the SDHSAA.

DATED this _____ day of _____, 20_____

_____ _____

Parent/Guardian (Print Name) Parent/Guardian Signature

THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL

This is the form that the South Dakota High School Activities Association recommends to those member schools that feel it is important to get consent from parents and/or legal guardians for medical treatment when away from home on road trips for various activities. This form should be kept on file at the school and another copy should travel with each team on which the athlete competes.

CONSENT FOR MEDICAL TREATMENT

I am the **PLEASE CIRCLE ONE** Mother Father Legal Guardian of_____

_____, who participates in co-curricular activities for _____

_____ High School. I hereby consent to any medical services that may be required while said child is under the supervision of an employee of the _____ School District while on a school-sponsored activity and hereby appoint said employee to act on behalf in securing necessary medical services from any duly licensed medical provider.

Dated this_____ day of _____, 20_____

Parent(s)/Legal Guardian Signature:_____

CONSENT OF CHILD

I, _____, have read the above Consent For Medical Treatment Form signed by my **(PLEASE CIRCLE ONE)** Mother Father Legal Guardian and join with **(PLEASE CIRCLE ONE)** him her in the consent.

Dated this _____ day of _____, 20_____

Student's Signature:_____

CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM (HIPAA)

Students Name _____ Date of Birth _____

1. I authorize the use or disclosure of the above named individual's health information including the Initial and Interim Pre-Participation History and Physical Exam information pertaining to a student's ability to participate in South Dakota High School Activities Association sponsored activities. Such disclosure may be made by any Health Care Provider generating or maintaining such information.

2. The information identified above may be used by or disclosed to the school nurse, athletic trainer, coaches, medical providers and other school personnel involved in the care of this student.

3. This information for which I am authorizing disclosure will be used for the purpose of determining the student's eligibility to participate in extracurricular activities, any limitations on such participation and any treatment needs of the student.

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the school administration. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

5. This authorization will expire on July 1, 2018.

6. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

7. I understand authorizing the use or disclosure of the information identified above is voluntary. However, a student's eligibility to participate in extracurricular activities depends on such authorization. I need not sign this form to ensure healthcare treatment.

_____ _____

Signature of Parent Date

This form must be completed annually and must be available for inspection at the school

CONCUSSION FACT SHEET FOR ATHLETES

What is a concussion?

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body
- Can change the way your brain normally works
- Can occur during practices or games in any sport or recreational activity
- Can happen even if you haven't been knocked out
- Can be serious even if you've just been "dinged" or "had your bell rung"

All concussions are serious. A concussion can affect your ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most people with a concussion get better, but it is important to give your brain time to heal.

What are the symptoms of a concussion?

You can't see a concussion, but you might notice one or more of the symptoms listed below or that you "don't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

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

- **Tell your coaches and your parents.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach right away if you think you have a concussion or if one of your teammates might have a concussion.
- **Get a medical check-up.** A doctor or other health care professional can tell if you have a concussion and when it is OK to return to play.
- **Give yourself time to get better.** If you have a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have another concussion. Repeat concussions can increase the time it takes for you to recover and may cause more damage to your brain. It is important to rest and not return to play until you get the OK from your health care professional that you are symptom-free.

How can I prevent a concussion?

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

- Use the proper sports equipment, including personal protective equipment. In order for equipment to protect you, it must be:
  - The right equipment for the game, position, or activity
  - Worn correctly and the correct size and fit
  - Used every time you play or practice
- Follow you coach's rules for safety and the rules of the sport
- Practice good sportsmanship at all times

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

Student's Name (please print)_____ Date: _____

Student's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

THIS FORM MUST BE SIGNED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL

CONCUSSION FACT SHEET FOR PARENTS

What is a concussion?

A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even or what seems to be a mild bump or blow to the head can be serious.

What are the signs and symptoms?

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 after the injury. If your teen reports, one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

Signs Observed By Parents or Guardians	Symptoms Reported by Athlete
• 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 • Can't recall events prior to hit or fall • Can't recall events after hit or fall	• Headache or "pressure" in head • Nausea or vomiting • Balance problems or dizziness • Double or blurry vision • Sensitivity to light or noise • Feeling sluggish, hazy, foggy, or groggy • Concentration or memory problems • Confusion • Just not "feeling right" or is "feeling down"

How can you help your teen prevent a concussion?

Every sport is different, but there are steps your teens can take to protect themselves from concussion and other injuries.

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport
- Encourage them to practice good sportsmanship at all times.

What should you do if you think your teen has a concussion?

1. **Keep your teen out of play.** If your teen has a concussion, her/his brain needs time to heal. Don't let your teen return to play the day of the injury and until a health care professional, experienced in evaluating for concussion, says your teen is symptom-free and it's OK to return to play. A repeat concussion that occurs before the brain recovers from the first – usually within a short period of time (hours, days, or weeks) – can slow recovery or increase the likelihood of having long-term problems. In rare cases, repeat concussions can result in edema (brain swelling), permanent brain damage, and even death.
2. **Seek medical attention right away.** A health care professional experienced in evaluating for concussion will be able to decide how serious the concussion is and when it is safe for your teen to return to sports.
3. **Teach your teen that it's not smart to play with a concussion.** Rest is key after a concussion. Sometimes athletes wrongly believe that it shows strength and courage to play injured. Discourage others from pressuring injured athletes to play. Don't let your teen convince you that s/he's "just fine".
4. **Tell all of your teen's coaches and the student's school nurse about ANY concussion.** Coaches, school nurses, and other school staff should know if your teen has ever had a concussion. Your teen may need to limit activities while s/he is recovering from a concussion. Things such as studying, driving, working on a computer, playing video games, or exercising may cause concussion symptoms to reappear or get worse. Talk to your health care professional, as well as your teen's coaches, school nurse, and teachers. If needed, they can help adjust your teen's school activities during her/his recovery.

Parent/Guardian's Name (Please print) _____ Date _____, 20_____

Parent/Guardian's Signature _____ Date _____, 20_____

THIS FORM MUST BE SIGNED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL

SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION
ANNUAL PARENT OR GUARDIAN PERMIT

I hereby give my consent for _____ GRADE _____
Name (Please Print) 2017-18 School Year

who was born at _____
City, Town, County, State

on _____ to compete in SDHSAA approved athletics for _____ High School
Date of Birth

during the 2017-18 school year.

I/We give our permission for our son/daughter to participate in organized high school athletics, realizing that such activity involves the potential for injury which is inherent in all sports.

Date _____, 20_____ Signed _____
Parent or Legal Guardian

THIS FORM MUST BE COMPLETED ANNUALLY AND MUST BE AVAILABLE FOR INSPECTION AT THE SCHOOL.

INITIAL PRE-PARTICIPATION HISTORY

SEE REVERSE SIDE FOR

HEALTH HISTORY QUESTIONNAIRE

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 _____

HE0503 9-2681/0410

SOUTH DAKOTA HIGH SCHOOL ACTIVITIES ASSOCIATION PHYSICAL EXAMINATION FORM

Date Exam Expires: _____

Check Appropriate Physical Exam Term:

___Annual ___Biennial___Triennial

NAME _____GRADE _____DATE OF BIRTH_____

CHECK ONE: _____ MALE _____FEMALE (2017-18 School Year)

1. Blood pressure (sitting) _____/_____ Repeat in 5 minutes, if elevated _____/_____.
2. Height _____
3. Weight _____

	Normal	Abnormal	COMMENTS
4. Vision 20/_____(L) 20/_____(R)			
5. Head			
6. Mouth (dentures, braces?)			
7. Eyes (contacts?)			
8. Chest/lung			
9. Heart			
a. Heart sounds			
b. Murmurs			
c. pulse (rad. vs fem.)			
d. rhythm			
10. Abdomen			
a. liver or spleen			
b. masses			
11. Genitalia (males only)			
a. hernias			
b. testes			
12. Orthopedic			
a. cervical spine			
b. shoulder shrug			
c. deltoid			
d. arms/elbow			
e. hands			
f. hips			
g. knees			
h. ankles			
i. Scoliosis			

SPORTS PARTICIPATION RECOMMENDED FOR:

_____ Cleared for ALL (*collision, contact/endurance sports*, and *other sports*)
_____ Cleared only for *contact/endurance sports* and *other sports*
_____ Cleared only for *other sports*

Definition: [Collision=Football and Wrestling]; [Contact/Endurance Sports=Basketball, Cross Country, Gymnastics, Soccer, Tennis, Track, Volleyball, Competitive Cheer and Competitive Dance]; [Other Sports=Golf]

_____ Cleared for ALL, but with recommendations for further evaluation or treatment for _____
_____ Above clearance to be granted only after _____
_____ **Clearance cannot be given at this time because**_____

NAME OF EXAMINER (PRINT) _____ DATE_____, 20_____

SIGNATURE OF EXAMINER _____

NOTE: The following licensed medical personnel are qualified to perform the examination and certify the health of the student athlete: Doctor of Medicine, Doctor of Osteopathy, Doctor of Chiropractic, licensed Physician Assistant and licensed Nurse Practitioner.

BIG STONE Therapies, Inc.

Student-Athlete Authorization and Consent Form for Disclosure of Protected Health Info

I hereby authorize the athletic trainer and other health care personnel representing _____, (name of school) to release information regarding the student-athlete's protected health information and related information regarding any injury or illness during the student-athlete's training for and participation in athletics at the above named school. I further understand that it is at my request to comply with the requirements of his/her school and the release of protected health information to a coach, athletic director, or school official in connection with participation in interscholastic sports. This protected health information may concern the student-athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected information may be released to other health care providers, hospital and/or medical clinics and laboratories, athletic coaches, medical insurance coordinators, athletic and/or school administrators, chaplains and/or clergy members, and officials of the WCAL and CIF.

I, _____, parent and/or guardian of _____, student-athlete, understand that as a parent/guardian give authorization/consent for the disclosure of the undersigned student-athlete's protected health information is a condition for participation as an interscholastic athlete at the above named school. I understand that my protected health information may be protected by the federal regulations under the Health Information Portability and Accountability Act (HIPAA) and, if so, may not be disclosed without either parent/legal guardian authorization under HIPAA. This authorization/consent expires one year from the date it is signed.

Important: Your Rights. I understand my rights, as described herein:

- I may revoke this authorization at any time by notifying the above named school's Athletic Director in writing. My letter must be hand delivered or mailed to the School.
- A revocation will not affect any uses or disclosures that the above named school made before it received my revocation.
- If I request it, I may see a copy of the health information described on this form.
- The information that is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA. I have the right to seek assurances from the above named entities or individuals authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.

Consent for ImPACT and Release of Information

I give my permission for (name of child) _____ to have a baseline and post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) as needed, administered at the above named school. I understand that my child may need to be complete ImPACT more than once post-concussion, depending upon the results, as compared to my child's baseline, which will be on file at the above named school. I understand there is no charge to complete the ImPACT.

The above named school may release the ImPACT results to my child's primary care physician, neurologist, team physician or other interpreting physician. I understand that as a parent/guardian, I give authorization/consent for the involved athletic trainer and/or health care personnel representing the above named school to contact the child's primary care physician, neurologist, team physician, or other treating physician, coach, athletic director, or school official regarding the results of the ImPACT

I understand that general information about the ImPACT data may be provided to my child's school nurse, guidance counselor and teachers, for the purposes of providing temporary academic modifications, if necessary.

_____	_____	_____
Print Student-Athlete's Name	Signature of Student-Athlete's Name	Date
_____	_____	_____
Print Parent/Guardian Name	Signature Parent/Guardian Name	Date