

Concussion, Head Injury and Sudden Cardiac Arrest

As a parent/guardian and as an athlete it is important to recognize the signs, symptoms, and behaviors of concussions and sudden cardiac arrest. By signing this form, you are stating that you have read the Department of Public Instruction's (DPI) and the Wisconsin Interscholastic Athletic Association (WIAA) Concussion and Head Injury information sheet and Sudden Cardiac Arrest Information sheet.

ATHLETE AGREEMENT

I, _____, have read the Concussion and Head Injury Information sheet. I have had the opportunity to read more information on concussions on the Centers for Disease Control and Prevention's (CDC) websites. I understand what a concussion is and how it may be caused. I also understand the common signs, symptoms, and behaviors. I understand the importance of reporting a suspected concussion to my coaches and my parents/guardian. I understand that I must be removed from practice/play if a concussion is suspected. I understand that I must be evaluated by an appropriate health care provider and provide to my coach written clearance to participate in the activity from the health care provider before I may return to practice/play. I understand that after a head injury my brain needs time to heal and that it may not heal properly if I return to practice/play too soon. I have read the Sudden Cardiac Arrest Information sheet. I understand that I should stop activity/exercise immediately if I have any warning signs of sudden cardiac arrest and report the symptoms to my coaches and my parents/guardians.

Athlete Signature: _____ *Date:* _____

PARENT / GUARDIAN AGREEMENT

I, _____, have read the DPI's Concussion and Head Injury Information sheet. I have had the opportunity to read more information about concussions on the Centers for Disease Control and Prevention's (CDC) websites. I understand what a concussion is and how it may be caused. I also understand the common signs, symptoms, and behaviors. I agree that my child must be removed from practice/play if a concussion is suspected. I understand that it is my responsibility to seek medical treatment if a suspected concussion is reported to me. I understand that my child cannot return to practice/play until they are evaluated by an appropriate health care provider and provide written clearance from the health care provider to their coach. I understand concussions can have a serious effect on a young, developing brain and need to be addressed correctly. I have read the Sudden Cardiac Arrest information sheet. I understand that my child should stop activity/exercise immediately if they have any warning signs of sudden cardiac arrest. I understand it is recommended if my child has any warning signs of sudden cardiac arrest while exercising, they have a medical examination before exercising or returning to participation in their sport. I understand that I or my child should report a family history of heart problems or warning signs of sudden cardiac arrest to the healthcare provider doing the medical examination. I understand how to request at my cost the administration of an electrocardiogram, in addition to a comprehensive physical examination required to participate in a youth athletic activity. I understand the athletic director may be able to assist me.

Parent/Guardian Signature: _____ *Date:* _____



Questions and Contact Information

St. Joseph School – Diocese of Superior

Name (of athlete) _____ Age _____

Address _____

City _____ Zip _____ County _____

Phone _____ Email _____

I participate in (check all that apply):

- Golf
- Volleyball
- Basketball
- Archery
- Speed/Agility Training
- Track
- Tennis

Have you ever had a concussion? _____ If yes, how many? _____

Have you ever experienced concussion symptoms? _____

Did you report them? _____

Emergency Contacts:

1) Name _____ Relationship _____

Phone Number _____

2) Name _____ Relationship _____

Phone Number _____