ASCENSION PARISH ATHLETIC TRAINING
RISK ACKNOWLEDGEMENT & CONSENT TO PARTICIPATE FORM

Please read carefully and fill in ALL blanks.

Name ____ Date of Birth ____________________

I wish to allow my child to participate in the sports at an Ascension Parish School.

I understand that injuries in this sport may occur, and, by consenting to my child's participation therein, I agree to hold the Ascension Parish School Board, its members, employees, agents, and/or assigns free and harmless from liability for any injuries suffered by my child during such participation. I also give my permission for team physicians to treat my child in the event of any injury requiring emergency treatment

If consent to participate is granted, please check the boxes below:

[ ] As a parent of the student whose name is listed above, we acknowledge that we have enrolled our child in primary insurance coverage. We understand that we are responsible for maintaining this primary coverage on our child throughout any period of time in which your child is participating.in any Ascension Parish Public School sponsored sports or sports related activity.

[ ] We further understand and agree that Ascension Parish School Board, its members, agents, and/or assigns shall not be held responsible payment of any such bills.

Medical Disclosure, (allergies, including medial or seasonal, asthma, glasses, daily medications, allergy, ADD/ADHD, inhaler, etc.)

*I understand failure to disclose medical condition(s) the athlete currently has or develops during the year, and medication(s) he/she is currently on or may be prescribed during the year can lead to injury or delay in appropriate health care.

*My child has the following conditions ____

____which require the following

medication ____

____

My child and I understand these concerns and agree to follow directions and recommendations of the athletic trainers, coaches, and physicians. We also agree to accept these additional risks to me as part of my participation in this program.

____ _____________________________________
(Parent Signature) (Date)

____ _____________________________________
(Athlete's Signature) (Date)

ASCENSION PARISH ATHLETIC TRAINING
ATHLETE CONCUSSION & INJURY STATEMENTS

By initialing below, I am aware of the following information:

Athlete & Parent's Initials
______/______ ***I understand participation in sport does have an inherent risk of injury.***

______/______ A concussion is a brain injury, which why student athlete is responsible for reporting to their athletic trainer, coach, or team physician.

______/______ A concussion can affect my ability to perform everyday activities, reaction time, balance, sleep, and classroom performance.

______/______ You cannot see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours after the injury.

______/______ Following a concussion, the brain needs time to heal. You are much more likely to have a repeat concussion if you return to play before your symptoms resolve,

______/______ In rare cases, repeat concussions can cause permanent brain damage and even death.

______/______ I should report any injury or illness I have to our athletic trainer or coach.

_____/_____ I understand that we have team physicians, and relationships with other medical partners. I know I do not have 10 use their services, but we have strong communication and access which aids in a seamless and timely care of injuries.

______/______ I understand that if I have an injury or illness and have been seen by a physician I am not allowed to return without proper documentation of that injury or illness. That documentation should include type of injury, any limitations, restrictions or release before returning to participation.

______/______ I understand that in the case of an injury sustained while I am participating in athletics, my private insurance is primary and the APSB insurance is then secondary. Injuries must first reported be to the Head Athletic Trainer. Only then can the completed forms be obtained.

______/______ If I take medication, and have a medical condition (asthma, diabetes, etc...) that requires me to take medication at school, the proper notification must be obtained from the school nurse and medication forms must be on file to be in compliance with APSB policy.

______/______ If I am sent to be treated by any APSB athletic trainer I understand it is my responsibility to go when scheduled, arrive on time, and bring any pertinent documentation with me. If I cannot go, it is my responsibility to ensure the athletic trainer is notified.

I have read and understood all information about concussions, what an athletic trainer's job is, and what to do when I have been hurt. I accept that if do not follow the directions above, that I am willing putting myself at risk for further injury.

______________________________ ______________________________ ______________________________
Athlete Name (Print) Athlete Signature Date

As the parent of the above-mentioned student, I am also aware of the issues concerning concussions, athletic training, and injuries, as mentioned in this document and agree to adhere to these guidelines.

______________________________ ______________________________ ______________________________
Parent Name (Print) Parent Signature Date

ASCENSION PARISH ATHLETIC TRAINING
CONCUSSION HISTORY FORM

Athlete's Name: ____ **Date:** _____________________

Concussion Questionnaire:

	YES	NO
Have you EVER had a concussion or had any of the symptoms from a head injury? *		
Have you ever lost consciousness because of a head injury?		
Have you ever been hospitalized because of a head injury?		
Have you ever had any imaging test of our brain (CT, MRI, DTI, other)?		

*If yes, previous number of concussions: ___________ Date(s): ________________________________

Did our Sports Medicine Staff handle the concussion protocol? Y / N

What type of symptoms did you have?

____

____

How long were you out of activity? ____

If ever ImPACT* tested, what was the most recent date? _____________________/_____________/_________________

*ImPACT testing is a neurocognitive baseline screening exam completed on a computer.

Personal History (check all that apply)

Have you ever been diagnosed with:

____ Headache or migraines

____ Learning disability/dyslexia

____ ADD/ADHD

____ Depression, anxiety or psychiatric disorder

____ Seizure disorder

____ Sinusitis

Family History (check all that apply)

Has anyone if your family been diagnosed with:

____ Headache or migraines

____ Learning disability/dyslexia

____ ADD/ADHD

____ Depression, anxiety or psychiatric disorder

____ Seizure disorder

____ Sinusitis

List medications you are currently taking for any of the above conditions:

____

Parent name: __________________________________ **Parent Signature:** ___________________________________

SPORTS MEDICINE STAFF ONLY:

KING DEVICK BASELINE TIME: _________________________ SCORE SHEET USED: 1 2 3

IMPACT TEST DATE: ________/_________/_________