WISCONSIN DEPARTMENT OF PUBLIC INSTRUCTION

PARENT & ATHLETE AGREEMENT

Related to Concussion Law 2011 – Wisconsin Act 172

As a Parent and as an Athlete it is important to recognize the signs, symptoms, and behaviors of concussions. By signing this form you are stating that you understand the importance of recognizing and responding to the signs, symptoms, and behaviors of a concussion or head injury. *This form must be completed for every sports season and every youth athletic organization the athlete is involved with.*

Parent Agreement:

I _____ have **read** the Parent Concussion and Head Injury Information and **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 providing written clearance from an appropriate health care provider to his/her coach.

I understand the possible consequences of my child returning to practice/play too soon.

Parent/Guardian
Signature_____Date_____

Athlete Agreement: I_____ have **read** the Athlete Concussion and Head

Injury Information and **understand** what a concussion is and how it may be caused. 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 provide written clearance from an appropriate health care provider to my coach before returning to practice/play.

I understand the possible consequence of returning to practice/play too soon and that my brain needs time to heal.

Athlete Signature_____Date_____

125 South Webster Street, PO Box 7841, Madison,WI53707-7841

PHONE 608-266-3390 TOLL FREE 800-441-4563 WEBSITE http://www.dpi.wi.gov

WISCONSIN DEPARTMENT OF PUBLIC INSTRUCTION

Questions and Contact Information

Re*lated to Concussion Law 2011 – Wisconsin Act 172*

Name_____Date_____

Address_____

City_____Zip_____County_____

Phone_____Email_____

Age_____ School _____School District_____

(This document must be completed at the beginning of every Capital volleyball season)

I participate in: Volleyball

Name of Current Team: CAPITAL VOLLEYBALL ACADEMY

1. Have you ever had a concussion?_____, if yes, how many?_____

2. Have you ever experienced concussion symptoms?_____ Did you report them?_____

Emergency Contacts: Name: _____

Relationship: _____

Phone Number: _____

Name: _____

Relationship: _____

Phone Number: _____

Please complete this form and return to the person operating the youth athletic activity.