AD______
AT______
RN______
PE_________
Official use only

STOUGHTON HIGH SCHOOL ATHLETICS

Permission Form
Interscholastic Athletics

Year of Grad:__________

SPORT: ______________

(Please fill this box in)

TO BE COMPLETED AND SIGNED BY PARENT /GUARDIAN

I give the coach/ representative of Stoughton High School my consent to seek whatever medical treatment may be necessary in the event that my son/daughter is injured or requires medical care while my son/daughter is under their supervision and a parent or another legal guardian is unable to be reached. I give the Athletic Training Staff permission to provide routine medical treatment within their scope of practice.

Student's Name__________________________________ Student Cell Phone #______________________

Date of Birth_______________ Gender: M or F Email:___________________________

Parent/ Guardian Name____

Home Phone_________________________ Father Cell Phone______________________

Work Phone_________________________ Mother Cell Phone ____________________

Email Address________________________ Alternate Emergency Contact____________________

Primary Care Physician ___________________________ Relationship ___________________________

Phone Number ___________________________

Phone Number _______________________ Health Ins Company___________________

List all medical conditions such as asthma, allergies, seizure disorders, diabetes, or others that your athlete has and the coach, certified athletic trainer or emergency medical personnel need to know about in order to provide proper care.

____

____

Is your student-athlete currently taking any medications (inhalers, epipen, daily medications)?
Y or N.

If yes, please list:____

Number of Head Injuries (and when, if known):____

Parent/ Guardian Signature: _________________________________ Date: ______________

PLEASE NOTE: All students participating in interscholastic sports will undergo a preparticipation ImPACT Test. The ImPACT test is a computerized neurocognitive assessment tool used to assist in determining an athlete's ability to return to play after suffering a head injury. If you choose not to have your child tested, please send a note to the athletic director indicating that your child should be exempt from the ImPACT testing.

PLEASE FILL OUT COMPLETELY ALL 3 FORMS

AGREEMENT FORM

1. **We assume responsibility for equipment issued to the student-athlete.**
2. **We have read and agree to follow ALL rules and regulations pertaining to Stoughton High School Athletics and the Massachusetts Interscholastic Athletic Association (www.MIAA.net).**
3. **We understand that the *Handbook of Athletic Standards* for Stoughton High School Athletics is subject to change prior to the Fall Athletics Season. We are responsible for understanding the changes before participating in a sport.**
4. **We understand the School EXCESS accident insurance policy. The school insurance is supplemental to our own insurance.**

We , the undersigned mother and father or guardian(s) of ____, a minor, do hereby consent to his/her participation in voluntary athletic programs and do forever RELEASE, acquit, discharge, and covenant to hold harmless, the town of Stoughton, a municipal corporation of the Commonwealth of Massachusetts, the school committee, the school department, its successors, departments, officers, employees, servants and agents, of and from any and all actions, causes of actions, claims, demands, damages, costs, loss of services, expenses, and compensation on account of or in any way growing out of directly or indirectly, all known and unknown personal injuries or property damages which we /I may now or hereafter have as parent(s) or guardian(s)of said minor, and also all claims or right of action for damages which said minor may acquire, either before or after he/she has reached his/her majority resulting or to result from his/her participation in the Stoughton Public Schools' Athletics Programs; FURTHERMORE, we/I hereby agree to protect the Town of Stoughton, The School Committee, the School Department, and its successors, departments, officers, employees, servants, and agents against any claims for damages, compensation or otherwise on the part of said minor growing out of or resulting from injury to said minor in connection with his/her participation in the Stoughton Public Schools' Athletics Programs, and to INDEMNIFY, reimburse or make good to the Town of Stoughton or its successors, departments, officers, employees, servants, and agents any loss or damages or costs including attorneys' fees, the Town Of Stoughton or its representatives may have to pay if any litigations arise from said minor's intentional, grossly negligent, or reckless acts or omissions while participating in said sports programs.

Concussion/Traumatic Brain Injury

Proof of Education

It is required by law for all participating student athletes and at least one parent/guardian to show proof of education about recognizing the signs and symptoms of potentially catastrophic head injuries, concussions and injuries related to second impact syndrome.

Minimum Requirements (1 or 2)	Parent/Guard	Student
1. Has carefully read & reviewed Stoughton High School Sports Medicine TBI guidelines & CDC "Heads up on Concussions" informational packet.	____________ Init	__________ Init
AND / OR		
2. The NFHS "Concussions in Sports – What You Need To Know" online tutorial, and has included completion code in the space below.	____________ Init	__________ Init

NFHS Website link to take Concussion Certification Course (30-45 minutes in length)
http://www.nfhslearn.com/electiveDetail.aspx?courseID=15000
You will need to provide your email address & create a password to complete this.
Completion Code (NFHS Online Course) ____

Student Signature____ **Date:** __________________

PLEASE FILL OUT COMPLETELY ALL 3 FORMS

REVISED 3/12 JJD

Parent/Guardian Signature: ____________________________ Date: ________________

STOUGHTON HIGH SCHOOL
PRE-PARTICIPATION HEAD INJURY/CONCUSSION
REPORTING FORM FOR EXTRACURRICULAR ACTIVITIES

This form should be completed by student's parent/guardian. It must be submitted to the Athletic Director/Marching Band Director or official designated by the school, prior to the start of each season that a student plans to participate in an extracurricular athletic activity/marching band.

Student's Name ___________________________Sex______Date of Birth___________

Grade ___________ Sport/Activity ____

Home Address ____Phone ____________

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) ____

Please describe the circumstances:____

____

Was the student diagnosed with a concussion? Yes _____ No _____

If yes, when? Dates (month/year) ____

Duration of symptoms (such as headache, difficulty concentrating, fatigue) for the most

recent concussion: ____

Parent/Guardian: Name: (Please print) **____________________________________**

Parent/Guardian: Signature/Date ____

Student: Signature/Date ____

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