PHYSICAL EXAMINATION AND PARENT PERMIT FOR ATHLETIC PARTICIPATION - PART I

I hereby certify that I have examined _____ and that the student was found physically fit to engage in high school sports (except as listed on back).

Student's birth date _____ Exp. Date (good for 365 days) _____

PARENT OR GUARDIAN PERMIT

WARNING: Although participation in supervised interscholastic athletics and activities may be one of the least hazardous in which any student will engage in or out of school, **BY ITS NATURE, PARTICIPATION IN INTERSCHOLASTIC ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CATASTROPHIC INJURY.** Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate this risk.

PLAYERS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACHES, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR OWN EQUIPMENT DAILY.

By signing this Permission Form, we acknowledge that we have read and understood this warning. **PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PERMISSION FORM. By signing this form it allows my students medical information to be shared with appropriate medical staff when necessary in compliance with HIPPA (Health Insurance Portability and Accountability Act) Regulations.**

I hereby give my consent for _____ to compete in athletics for High School in Colorado High School Activities Association approved sports, except as listed on back, and I have read and understand the general guidelines for eligibility as outlined in the Competitor's Brochure.

Parent or Guardian Signature _____ Date _____

I have read, understand and agree to the General Eligibility Guidelines as outlined in the Competitor's Brochure.

Student Signature _____ Date _____

No student shall represent their school in interschool athletics until there is on file with the superintendent or principal a statement signed by his parent or legal guardian and a signed physical certifying that he/she has passed an adequate physical examination within the past year, that in the opinion of the examining physician, physician's assistant, nurse practitioner or a certified/registered chiropractor, he/she is physically fit to participate in high school athletics; and that he/she has the consent of his/her parents or legal guardian to participate.

NOTE: It is strongly recommended by the Colorado Department of Health that individuals participating in athletic events have current tetanus boosters. Tetanus boosters are recommended every 10 years throughout life. Boosters are recommended at the time of injury if more than five years have elapsed since the last booster.

If significant intervening illnesses and/or injuries have occurred, a more complete physical examination should be conducted. The physical examination form must be signed by a practicing physician, physician assistant, or nurse practitioner.

If a student athlete has been injured in practice and/or competition, the nature of which required medical attention, the student athlete should not be permitted to return to practice and/or competition until he/she has received a release from a practicing physician.

NOTE: The CHSAA urges an adequate physical examination be given when a student athlete changes levels of competition, i.e. Little League to Middle School, Middle School to High School.

PHYSICIAN SIGNATURE REQUIRED ON BACK

PART II -- MEDICAL HISTORY

This form must be completed and signed, prior to the physical examination, for review by examining physician. Explain "Yes" answers below with number of the question. Circle questions you don't know the answers to.

	MEDICAL HISTORY OF STUDENT & FAMILY	YES	NO		MEDICAL HISTORY OF STUDENT & FAMILY	YES	NO
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐	32.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐	33.	Have you ever had herpes skin infection?	☐	☐
3.	Are you currently taking any prescription or non-prescription (over the counter) medicines or pills?	☐	☐	34.	Have you ever had a head injury or concussion?	☐	☐
4.	Do you have allergies to medicines, pollens, foods or stinging insects?	☐	☐	35.	Date of last head injury or concussion:		
5.	Do you have prescriptions for use of epinephrine, adrenalin, inhaler, or other allergy medications?	☐	☐	36.	Have you ever been hit in the head and been confused or lost your memory?	☐	☐
6.	Have you ever passed out or nearly passed out during or after exercise?	☐	☐	37.	Have you ever been knocked unconscious?	☐	☐
7.	Have you ever passed out or nearly passed out at any other time?	☐	☐	38.	Have you ever had a seizure?	☐	☐
8.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐	39.	Do you have headaches with exercise?	☐	☐
9.	Have you ever had to stop running after ¼ to ½ mile for chest pain or shortness of breath?	☐	☐	40.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
10.	Does your heart race or skip beats during exercise?	☐	☐	41.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
11.	Has a doctor ever told you that you have (check all that apply): ☐ High Blood Pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection			42.	When exercising in heat, do you have severe muscle cramps or become ill?	☐	☐
				43.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
12.	Has a doctor ever ordered a test for your heart?	☐	☐	44.	Have you had any other blood disorders or anemia?	☐	☐
13.	Has anyone in your family died suddenly for no apparent reason?	☐	☐	45.	Have you had any problems with your eyes or vision?	☐	☐
14.	Does anyone in your family have a heart problem?	☐	☐	46.	Do you wear glasses or contact lenses?	☐	☐
15.	Has any family member or relative died of heart problems or sudden death before age 50? (This does not include accidental death.)	☐	☐	47.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
16.	Does anyone in your family have Marfan syndrome?	☐	☐	48.	Are you happy with your weight?	☐	☐
17.	Have you ever spent the night in a hospital?	☐	☐	49.	Are you trying to gain or lose weight?	☐	☐
18.	Have you ever had surgery?	☐	☐	50.	Do you limit or carefully control what you eat?	☐	☐
19.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendonitis that caused you to miss a practice or game?	☐	☐	51.	Has anyone recommended you change your weight or eating habits?	☐	☐
20.	Have you had any broken or fractured bones or dislocated joints?	☐	☐	52.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐
21.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches?	☐	☐	53.	What is the date of your last Tetanus immunization? Date: _____		
22.	Have you ever had a stress fracture?	☐	☐		FEMALES ONLY		
23.	Have you ever had an x-ray of your neck for atlanto-axial instability? OR Have you ever been told that you have that disorder or any neck/spine problem?	☐	☐	54.	Have you ever had a menstrual period?	☐	☐
				55.	Age when you had your first menstrual period?		
24.	Do you regularly use a brace or assistive device?	☐	☐	56.	How many periods have you had in the last 12 months?		
25.	Have you ever been diagnosed with asthma or other allergic disorders?	☐	☐	57.	Do you take a calcium supplement?	☐	☐
26.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐		**Explain "Yes" answers here:**		
27.	Is there anyone in your family who has asthma?	☐	☐				
28.	Have you ever used an inhaler or taken asthma medicine?	☐	☐				
29.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐				
30.	Have you had infectious mononucleosis (mono) within the last three months?	☐	☐				
31.	Have you ever had mono or any illness lasting more than two weeks?	☐	☐				

Parent/Guardian Signature: _____

Athlete's Signature: _____

PART III -- PHYSICAL EXAMINATION

NAME: _____ SCHOOL: _____

HEIGHT: _____ WEIGHT: _____ SEX: _____ AGE: _____ DOB: _____

*Tanner Stage or Maturation Index? (males only): _____

*Percent Body Fat: _____

*Audiogram _____

BP: _____

Pulse: *(rest) _____

*(Exercise) _____

*(Recovery) _____

*FEV or Peak Flow (rest) _____

*(Exercise) _____

*(Recovery) _____

* Vision: Corrected: (L) _____ (R) _____ (Both) _____

Uncorrected (L) _____ (R) _____ (Both) _____

	N	Abnormal		N	Abnormal
Eyes			Cervical Spine/neck		
Ears			Back		
Nose			Shoulders		
Throat			Arm/elbow/wrist/hand		
Teeth			Knees/hips		
Skin			Ankle/feet		
Lymphatic			Marfan Screen		
Lungs			*Urine		
Heart			*Hemoglobin or HCT and or Iron stores		
Peripheral pulses			^Echocardiogram		
Abdomen			^Neuropsyc Testing		
Genitalia/hernia (male only)			^Pelvic Examination		

***WHEN MEDICALLY INDICATED**
(Physician judgment based on history, exam, and knowledge of other recent physical and laboratory evaluations)

^WITH SPECIAL INDICATIONS
(These studies may be recommended to the athlete because of history or physical findings and may or may not be required before making participation decision.)

I have reviewed the data above, reviewed his/her medical history form and make the following recommendations for his/her participation in athletics.

- ☐ **CLEARED WITHOUT RESTRICTIONS**
- ☐ Cleared **AFTER** further evaluation or treatment for: _____
- ☐ Cleared for **Limited participation** (check and explain "reason" for all that apply):
  - ☐ Not cleared for (specific sports): _____
  - ☐ Cleared only for (specific sports): _____
    Reason(s): _____
- ☐ **NOT CLEARED FOR PARTICIPATION:** _____
  Reason(s): _____
- ☐ Other Recommendations: _____
  - ☐ Recommend monitoring during early conditioning because of weight/fitness/other
  - ☐ Recommend restrictions or monitoring of weight loss or gain
  - ☐ Other: Reasons: _____

MD/DO, PA, NP, DE-SPC#, Signature: _____

Date of Examination: _____ Date Signed: _____

NAME OF PHYSICIAN/PA/NURSE PRACTITIONER/CERTIFIED-REGISTERED CHIROPRACTOR and degree: (print):

_____

Address: _____

City _____ State _____ Zip _____

HOLYOKE JR/SR HIGH SCHOOL
RANDOM DRUG AND ALCOHOL TESTING PROGRAM
CONSENT TO TEST FORM

Student Name: _____ Student ID # _____
(Leave Blank)

The student and his/her parent(s) or guardian acknowledge that the Holyoke RE-1J School District has the right to perform random drug and alcohol testing on students who wish to exercise the privilege of participating in athletic/extracurricular activities.

The student and his her parent(s) or guardian understand that as a condition of the student being allowed to participate in extracurricular activities in the District, the student may be required to undergo and successfully pass random screening for alcohol, illegal drugs or other banned substances, as set forth in the District's Drug Testing Policy for Students Involved in Athletics and Extracurricular Activities at Holyoke JR/SR High School. The student and his/her parent(s) or guardian acknowledges that they have read and understand this policy and that they agree to all terms and conditions contained in the policy and procedure.

The student and his/her parent(s) or guardian hereby consents to participate in the Random Drug and Alcohol Testing Program and to the disclosure of testing results to the District's Drug Program Coordinator and parent(s) and guardians. The student and his/her parent(s) or guardian further understand that the student's refusal to submit to a drug screening will be treated in the same manner as if the student had tested positive for banned substances.

The student and his/her parent(s) or guardian may voluntarily consent to participate in the random drug and alcohol testing program and to the disclosure of testing results to the District's Drug Program Coordinator and parent(s) or guardian.

No student shall be penalized academically for testing positive for banned substances during random drug testing. The privilege of being allowed to participate in athletics/extracurricular activities in the Holyoke RE-1J School District is contingent on the signing of this consent form.

This consent form shall remain in effect for the entire school year. Any revocation of this consent form shall disqualify the student from participating in athletics/extracurricular activities for the remainder of the school year. I am volunteering to be placed in the drug testing pool.

_____ _____
Student Name – Please Print Current Grade

_____ _____
Student Signature Date

_____ _____
Parent/Guardian Name – Please Print Work Phone

_____ _____
Parent/Guardian Signature Date

_____ _____
Home Phone Cell Phone # w/ Area Code

HOLYOKE SCHOOL DISTRICT RE-1J
CENTENNIAL MENTAL HEALTH CENTER, INC.
Release of Information or Authorization
Mental Health and/or Substance Abuse

☒ This Release also serves as a Request For Information

Origin of Authorization: ☒ Internal ☒ External Direction of Authorization: ☒ Outgoing ☒ Incoming

I, _____ _____ Hereby authorize
Name of Student Date of Birth

Centennial Mental Health Center		115 N Campbell	Holyoke	80734
Name		Address	City	Zip
AND	Drug Coordinator:	545 E Hale St	Holyoke	80734
Other	Angela Powell	Address	City	Zip
Agency:	Holyoke Jr./Sr. High School			
	Contact Person			

To Release the Following Information: (Check all that apply)

☐ All Clinical Records ☐ Evaluation/Assessment ☐ Physician's Records
☒ Lab Reports ☐ Service Plans ☐ Progress Notes
☐ Attendance / Participation / Progress ☐ Discharge/Transfer Summary ☒ Verbal Discussions
☐ Other _____

For the Purpose of:
☒ Treatment (Internal & External) ☒ Operations (Administrative) ☒ Payment (Reimbursement)
☐ Other (Indicates HIPAA Authorization, use only when necessary) Specify: Drug testing

Periods of Treatment: ☒ All Treatment Episodes ☐ Current Treatment Episode
☐ Specific Treatment Episode: Begin Date: _____ End Date: _____

If the purpose of this disclosure is marked as "Other" whether or not Treatment, Payment or Operations are checked, then this is a HIPAA Compliant Authorization. As such, the Center may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this Authorization and must provide me a copy.

I understand that my records or those of the individuals listed above are protected under state and federal Substance Abuse and Mental Health confidentiality regulations including 42CFR Part 2. Information cannot be disclosed without my written consent, unless otherwise specifically provided for in the regulations. I understand and agree that this release form may be sent to the agencies and persons identified above. Copies of this form may be used in lieu of the original.

I understand there is potential for information disclosed as a result of this release/authorization to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken based upon it. This consent expires and cannot be used past the indicated date or event.

Expiration Date: _____ OR Expiration Event: _____
365 days from date of signature

X _____ _____
Student Signature (only if 18 years or older) Date

_____ _____ _____
Signature of Parent, Guardian or Authorized Representative Relationship/Authority Date

_____ _____
Drug Coordinator Signature or Witness Signature Date

Consent revoked: _____ _____
Consumer or Guardian Signature Date

A COPY OF THIS RELEASE SHOULD BE PROVIDED TO THE CONSUMER

CONSENT FOR PARTICIPATION/TREATMENT
AND INSURANCE INFORMATION FORM

I HEREBY GRANT PERMISSION TO THE Holyoke School District Re-1J and its duly authorized representatives, to administer/consent to first aid, emergency medical care, or surgical care deemed reasonably necessary to the health and well being for my son or daughter.

Also, when necessary for executing such care, I grant permission for hospitalization at an accredited hospital.

I understand that this is to prevent undue delay and assure prompt treatment. And, that only a licensed physician will be engaged unless emergency medical or school personnel are needed to be utilized for immediate help until such time professional services can be obtained.

Insurance: Parent and Participant understand that the District's insurance coverage will not pay for injuries to Participant or any medical care provided to Participant, and that Parent and Participant shall be solely responsible for payment for any treatment or services provided to Participant. Parent and Participant shall promptly pay for any treatment provided to Participant, and shall indemnify and hold harmless the District from any claim, cost or expense related to any treatment provided to student. Every Student participating in any sports must be covered by some type of medical/accident insurance.

(Parents will be notified in case of serious illness or injury as quickly as they can be reached. Your signature on the bottom of this "Consent for Treatment Form" will allow immediate treatment of the participant, if necessary and in your absence.)

CONTACT INFORMATION:

Student's Name:_____

Grade Level:_____Birth Date:_____

Home Address:_____ Home Phone:_____
Parent's/Guardian's Place of Work:_____
Parent's/Guardian's Name_____Cell Phone:_____
Emergency Contact Name and Number_____

My child is presently taking the following medication:

_____

_____

My child has the following medical conditions needing special treatment, foods, or care, etc.:

_____

_____

Insurance Company:_____Policy Number:_____
Family Physician's Name_____ Work Phone:_____

I certify that my child is covered by medical/accident insurance with the above company.
I student and parent acknowledge that we have read and understand the material contained in the above statements.
CHECK ONE:

_____I consent that treatment can be given under the above conditions/situations.
If brief hospitalization is required, I give my consent for his/her release to a school representative upon completion of treatment.

_____I do not consent to any medical help/treatment for any reason until I am contacted.

_____

Date **Parent/Guardian Signature**

_____

Date **Student Signature**

COMMITMENT TO ACTIVITIES / ATHLETICS

I have received, read, and understand the Holyoke School District RE-1J Activity / Athletic Handbook as well as any additional individual team rules or handbooks. I agree to abide by the requirements and guidelines of those handbooks and/or rules and will strive to become the best person and participant/athlete I can.

SPORTS

FOOTBALL, VOLLEYBALL, SOFTBALL, GOLF,

BASKETBALL, WRESTLING, SWIMMING

BASEBALL, TRACK & FIELD, CHEERLEADING

ACTIVITIES

FBLA, FCCLA, FFA, NHS, Cadenza Club, Spanish Club,

Book Club, Science Club, Drama Productions, Select Choir,

Student Council, Flag Team, Jazz Band, Pep Band

_____

(Participant/Athlete Name-**Please Print**)

_____

(Participant/Athlete Signature) (Date)

_____

(Parent Name-**Please Print**)

_____

(Parent Signature) (Date)

RELEASE OF LIABILITY, WAIVER OF CLAIMS, ASSUMPTION OF RISKS

By signing this document you will waive certain legal rights, including the right to sue. Please read carefully!

ASSUMPTION OF RISKS:

I am aware that participation in extra-curricular activities, including school sports, involves certain inherent risks, dangers and hazards including but not limited to- bodily injury or death.

I also understand that the Holyoke School District cannot accept responsibility for the acts or omissions of private parties. I understand that I am responsible for my own health, medical, dental insurance and have decided not to purchase coverage made available by the Holyoke School District. I freely accept and fully assume all costs, risks, dangers and hazards and the possibility of personal injury, death, property damage, expense and other loss and delay or inconvenience resulting therefrom or from acts or omissions of the Holyoke School District, its employees, representatives, agents and volunteers.

RELEASE OF LIABILITY, WAIVER OF CLAIMS:

In consideration of the Holyoke School District allowing (student's name) _____ to participate in extra-curricular activities, including school sports, I hereby agree as follows:

1. TO WAIVE ANY AND ALL CLAIMS that I have or may have in the future against the Holyoke School District, its employees, representatives, agents and volunteers, arising directly or indirectly from my use.

2. TO RELEASE THE HOLYOKE SCHOOL DISTRICT from any and all liability for any loss, damage, injury or expense that I may suffer or that my next of kin may suffer as a result of my use, but not limited to, NEGLIGENCE, BREACH OF CONTRACT, or BREACH OF ANY STATUTORY OR OTHER DUTY OF CARE.

3. THAT THIS AGREEMENT shall be effective and binding upon my heirs, next of kin, executors, administrators and assigns, in the event of my death or incapacity.

4. THAT THE TERMS of this Release and Waiver of Claims shall apply, and have priority over any previous agreement or written agreement, representation, terms or conditions to the contrary.

5. This Agreement shall be governed by and interpreted in accordance with the laws of the State of Colorado.

6. Any litigation involving the parties to this Agreement shall be brought within the State of Colorado.

I HAVE READ AND UNDERSTOOD THIS AGREEMENT PRIOR TO SIGNING IT, AND I AM AWARE THAT BY SIGNING THIS AGREEMENT I AM WAIVING CERTAIN LEGAL RIGHTS WHICH I OR MY HEIRS, NEXT OF KIN, EXECUTORS, ADMINISTRATORS AND ASSIGNS MAY HAVE AGAINST HOLYOKE SCHOOL DISTRICT.

_____ _____

Parent / Guardian Signature Date

This agreement must be completed in full, signed and dated before use.

DESCARGO DE RESPONSABILIDAD, RENUCNIA A RECLAMACIONES,

ASUNCION DE RIESGOS

Al firmar este documento, usted renuncia a ciertos derechos legales, incluido el derecho de a demandar.

Por favor, lea con cuidado!

ASSUNCION DE RIESGOS:

Soy consciente que la participación en actividades extra-curriculares, incluyendo deportes de la escuela, implica ciertos riesgos inherentes, los peligros y los riesgos, incluyendo, pero no limitado a daños corporales o la muerte.

También entiendo que el Distrito Escolar de Holyoke no puede aceptar la responsabilidad por los actos u omisiones de los particulares. Yo entiendo que soy responsable de mi propia salud, seguro médico, dental y he decidido no comprar la cobertura facilitada por el Distrito Escolar de Holyoke. Yo libremente acepto y asumo todos los costos, riesgos, peligros y la posibilidad de lesiones corporales, muerte, daños a la propiedad, los gastos y otras perdidas y retraso o inconveniente resultante de la misma o de los actos u omisiones del Distrito Escolar De Holyoke, sus empleados, representantes, agentes y voluntarios.

DESCARGO DE RESPONSABILIDAD, RENUNCIA A RECLAMACIONES

Teniendo en cuenta el Distrito Escolar De Holyoke permitiendo (nombre del estudiante) _____ a participar en actividades extra-curriculares, incluyendo deportes de la escuela por la presente acuerdan los siguientes:

1. RENUNCIAR A TODO RECLAMO que tenga o pueda tener en el futuro contra el Distrito Escolar de Holyoke, sus empleados, representantes, agentes y voluntarios, qué resulten directamente o indirectamente por el uso.

2. PARA LIBRAR AL DISTRITO ESCOLAR DE HOLYOKE de cualquier y toda responsabilidad por cualquier perdida, daños, lesión o gastos que pueda sufrir o que mis familiares puedan sufrir como resultado de mi uso, pero no limitado, a NEGLIGENCIA,INCUMPLIMIENTO DE CONTRATO , O INCUMPLIMIENTO DE UN DEBER LEGAL O DE OTRO DEBER DE CUIDADO.

3. QUE EL PRESENTE ACUERDO será efectiva y vinculante para mis herederos, familiares, albaceas, administradores y cesionarios, en caso de mi muerte o incapacidad.

4. QUE SE APLICARA LOS TERMINOS de esta publicación y renuncia de reclamaciones y tienen prioridad sobre cualquier acuerdo anterior o acuerdo escrito, representación, términos o condiciones del contrario.

5. Este acuerdo se regirá e interpretara de acuerdo con las Leyes del Estado de Colorado.

6. Cualquier litigio entre las partes de este convenio deberá presentarse en el Estado de Colorado.

HE LEIDO Y COMPRENDIDO ESTE ACUERDO ANTES DE FIRMAR,Y ESTOY CONSIENTE QUE AL FIRMAR ESTE ACUERDO ESTOY RENUNCIANDO A CIERTOS DERECHOS LEGALES QUE YO O MIS HEREDEROS,FAMILIARES,ALBACEAS,ADMINISTRADORES Y CESIONARIOS PUEDAN TENER CONTRA EL DISTRITO ESCOLAR DE HOLYOKE.

_____ _____

Firma Del Padre O Tutor Fecha

Este acuerdo debe ser completado en su totalidad, firmado y fechado antes de su uso.

Holyoke High School
Concussion Fact Sheet for Athletes and Parents

WHAT IS A CONCUSSION

A concussion is an injury that changes how the cells in the brain normally work. A concussion is caused by a blow to the head or body that causes the brain to move rapidly inside the skull. Even a "ding", "getting your bell rung", or what seems to be a mild bump or blow to the head can be serious. Concussions can also result from a fall or from players colliding with each other or with obstacles, such as goalposts.

WHAT ARE THE SIGNS AND SYMPTOMS OF A CONCUSSION

Observed by the Athlete

- Headache or "pressure" in the head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light
- Bothered by noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion
- Does not "feel right"

Observed by the Parent/Guardian, Coach or Teammate

- 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 behavior or personality changes
- Can't recall events after hit or fall
- Appears dazed or stunned

WHAT TO DO IF SIGNS/SYMPTOMS OF A CONCUSSION ARE PRESENT

Athlete

- TELL YOUR COACH IMMEDIATELY
- Inform Athletic Trainer
- Inform parents
- Seek medical attention
- Give yourself time to recover

Parent/Guardian

- Seek medical attention
- Keep your child out of play
- Discuss return to play with athletic trainer and coaches
- Address academic needs

WHERE CAN I FIND MORE INFORMATION?

- Center for Disease Control www.cdc.gov/concussion/HeadUp/youth.html
- NFHS Free Concussion Course http://nfhslearn.com/electiveDetail.aspx?courseID=15000

- Kendra Schlachter, Certified Athletic Trainer at HHS (308)249-5294

RETURN TO PLAY GUIDELINES

1. Remove immediately from activity when signs/symptoms are present
2. Release from medical professional required for return (Neuropsychologist, MD, DO, Nurse Practitioner, Certified Athletic Trainer, or Physician Assistant)
3. Follow the school's return to play guidelines and protocol. (A 5 Day Return To Play Guideline)

SIGNATURES

By signing below, I acknowledge that I have received and reviewed the attached Holyoke High School Concussion Fact Sheet for Athletes and Parents. I also acknowledge and I understand the risks of brain injuries associated with participation in school athletic activity.

_____	_____	_____
Athlete's Signature	Print Name	Date
_____	_____	_____
Parent/Guardian Signature	Print Name	Date

1b

Colorado High School Activities Association

STUDENT ELIGIBILITY INFORMATION FORM
and
CHSAA Anti-Hazing Policy

I hereby give my consent for_____

to compete in athletics for _____High School in Colorado High School Activities Association approved sports, except as noted on the Physical Examination and Parent Permit Form, and I have read and understand the general guidelines for eligibility as outlined in the CHSAA Competitor's Brochure (as found on the CHSAANow.com website).

Parent or Guardian Signature_____ Date _____

I have read, understand and agree to the General Eligibility Guidelines as outlined in the CHSAA Competitor's Brochure.

Student Signature _____ Date _____

No student shall represent their school in interschool athletics until there is a statement on file with the superintendent or principal signed by his/her parent or legal guardian and a signed physical form certifying that he/she has passed an adequate physical examination within the past year, noting that in the opinion of the examining physician, physician's assistant, nurse practitioner or a certified/registered chiropractor, (DC, Spc.) is physically fit to participate in high school athletics; that student has the consent of his/her parents or legal guardian to participate; and, the parent and participant have read, understand and agree to the CHSAA guidelines for eligibility.

CHSAA Anti-Hazing Policy

The Colorado High School Activities Association prohibits bullying, hazing, intimidation or threats. Hazing includes, but is not limited to humiliation tactics, forced social isolation, verbal or emotional abuse, forced or excessive consumption of food or liquids, or any activity that requires a student to engage in illegal activity. I understand that hazing of any type is not permitted in any CHSAA sanctioned activity.

I will not engage in any of the prohibited conduct. I further understand that it is my responsibility to immediately report any acts of hazing that I become aware of to a sponsor, teacher, counselor, school support staff, coach or administrator in my school.

By signing this acknowledgement, I affirm my responsibility to prevent and report hazing. I also understand that any violation of this could result in school or team consequences that could include dismissal from the activity or further disciplinary consequences and/or referral to law enforcement.

_____ _____

Student Athlete Signature Date

Colorado High School Activities Association

STATEMENT OF CODE OF ETHICS
COLORADO HIGH SCHOOL ACTIVITIES ASSOCIATION

In order to be of maximum effectiveness in serving and fostering the education of the students so entrusted to us and in promoting and supplementing the regular curriculum, it is the duty of all concerned with our secondary athletic and activities programs to . . .

1. Cultivate an awareness that participation in athletics and activities is part of the total educational process and as such, the coach/advisor should neither seek nor expect academic privileges for the participants.

2. Emphasize the proper ideals of sportsmanship, ethical conduct and fair play as they relate to the lifetime impact on the participants.

3. Develop a working awareness and understanding of all rules and guidelines governing competition, both in letter and intent.

4. Recognize that the purpose of athletics and activities is to promote the physical, mental, moral, social and emotional well-being of the individual participants.

5. Avoid any practice or technique which would endanger the present or future welfare or safety of any participant.

6. Adhere to policies which do not force or encourage students to specialize or restrict them from participation in a variety of activities.

7. Refuse to disparage an opponent, an official, an administrator or spectator in any aspect of the activity.

8. Strongly encourage the development of proper health habits: the non-use of chemicals, including alcohol, steroids, tobacco in any form and other mood-altering substances.

9. Exemplify proper self-control at all times, accepting adverse decisions without public display of emotion or dissatisfaction with the officials or judges.

10. Encourage all to judge the true success of the athletic and activities programs on the basis of the attitude of the participants and spectators, rather than on the basis of a win or loss.