

PARENT-ATHLETE RULES OF ELIGIBILITY

SIGN-OFF FORM 2020 – 2021

I certify that I have read, understand, and agree to abide by all of the information contained in this bulletin. I further certify that if I have not understood any information contained in this document, I have sought and received an explanation of the information prior to signing this statement.

Guardian and athlete initials: _____

Extra/Co-Curricular CODE OF CONDUCT

Requesting the parent and student signature on this page is done to help ensure students/parents awareness of the Extra/Co-Curricular code, however failure to have a signature page on file does not exempt a student from this code.

Guardian and athlete initials: _____

CONCUSSION POLICY

Statement Acknowledging Receipt of Education and Responsibility to report signs or symptoms of concussion to be included as part of the “Participant and Parental Disclosure and Consent Document”.

I, _____, the student/athlete hereby acknowledge having received education about the signs, symptoms, and risks of sport related concussion. I also acknowledge my responsibility to report to my coaches, parent(s)/guardian(s) any signs or symptoms of a concussion. I certify that I have read, understand, and agree to abide by all of the information contained in this sheet. I further certify that if I have not understood any information contained in this document, I have sought and received an explanation of the information prior to signing this statement.

I, _____ the parent/guardian of the student athlete named above, hereby acknowledge having received education about the signs, symptoms, and risks of sport related concussion. I certify that I have read, understand, and agree to abide by all of the information contained in this sheet. I further certify that if I have not understood any information contained in this document, I have sought and received an explanation of the information prior to signing this statement.

CONSENT TO TREAT

I, _____ the parent/guardian of the student athlete named above, hereby authorize a Licensed Athletic Trainer to treat injuries that may occur to my student athlete during athletics. Injuries including, but not limited to: sprains, strains, fractures, cuts, abrasions, concussions, dislocation and other athletic injuries. During an emergency, the Licensed Athletic Trainer may do what is necessary to ensure the safety and health of the athlete, such as begin treatment, activate the EMS system if necessary and contact the parent/guardian about further treatment the athlete might need. As a guardian, you retain the right to take your child to a physician or specialist at any time. If a physician is consulted, please obtain documentation from the visit for the Licensed Athletic Trainer. The parent/guardian also grants the Licensed Athletic Trainer permission to discuss an athlete’s medical information with coaches and appropriate staff.

Your signature below indicates you have read and understand and accept the Parent-Athlete Rules of Eligibility, the Extra/Co-Curricular Code of Conduct, the Consent to Treat, and the Wisconsin State Concussion Policy. The following signatures are required prior to practice or competition for any Hillsboro Athletes.

The administration retains the right to deal with any action not covered by this handbook. Administration may vary from the discipline offense procedures whenever the act deems necessary, but will always remain in accordance with WIAA guidelines.

Parent/Guardian signature _____ Please Print Name _____ Date _____

Student-Athlete Signature _____ Please Print Name _____ Date _____

ATHLETIC EMERGENCY LOCATOR FORM

| | | | |
|----------------|--|---------------|--|
| Athlete's Name | | Date of Birth | |
| Parent Name | | | |
| Address | | | |
| Phone Number | | Cell Number | |

Does your student live with you? If not, please list additional contact information.

| | | | |
|--------------|--|-------------|--|
| Parent Name | | | |
| Address | | | |
| Phone Number | | Cell Number | |

INSURANCE INFORMATION

| | | | |
|-------------------|--|-------|--|
| Insurance Company | | ID# | |
| Medical Clinic | | Phone | |
| Hospital | | Phone | |
| Dental | | Phone | |

EMERGENCY CONTACT

| | | | |
|--------------|--|--------------|--|
| Name | | Relationship | |
| Address | | | |
| Phone Number | | Cell Phone | |

| | | | |
|--------------|--|--------------|--|
| Name | | Relationship | |
| Address | | | |
| Phone Number | | Cell Phone | |

| | | | |
|--------------|--|--------------|--|
| Name | | Relationship | |
| Address | | | |
| Phone Number | | Cell Phone | |

ALLERGIES OR OTHER MEDICAL CONDITIONS

| | |
|--|------|
| | |
| In the event that either parent or emergency contact person cannot be contacted by telephone I authorize the Hillsboro School District to use discretion and seek medical attention/transportation. | |
| | |
| Parent Signature | Date |