



# PARENT & ATHLETE AGREEMENT

Related to Concussion Law WI Stat. 118.293

**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 on file for every sports season and every youth athletic organization the athlete is involved with and must be renewed each school year (clubs- every 365 days).*

## 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 \_\_\_\_\_

# Questions and Contact Information

Related to Concussion Law WI Stat. 118.293

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Age \_\_\_\_\_ School \_\_\_\_\_ School District \_\_\_\_\_

Check all that apply  
I participate in:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Football      | <input type="checkbox"/> Baseball/Softball | <input type="checkbox"/> Basketball        | <input type="checkbox"/> Hockey              |
| <input type="checkbox"/> Soccer        | <input type="checkbox"/> Golf              | <input type="checkbox"/> Volleyball        | <input type="checkbox"/> Wrestling           |
| <input type="checkbox"/> Track & Field | <input type="checkbox"/> Cross Country     | <input type="checkbox"/> Cheerleading      | <input type="checkbox"/> Skiing/Snowboarding |
| <input type="checkbox"/> Gymnastics    | <input type="checkbox"/> Tennis            | <input type="checkbox"/> Swimming & Diving |  |
| <input type="checkbox"/> Other _____   |  |  |  |

Name of Current Team \_\_\_\_\_

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.