XAVIER MIDDLE SCHOOL circle one: **5 6 7 8**

ATHLETIC EMERGENCY LOCATOR FORM

Athlete's Name		**Date of Birth**	
Parent's Name			
Address			
Phone Number		**Cell Phone**	
Does your student live with you? If not, please list additional contact information.			
Parent's Name			
Address			
Phone Number		**Cell Phone**	

Insurance Company			**ID#**	
Medical Clinic	**Name**		**Phone**	
Hospital	**Name**		**Phone**	
Dental	**Name**		**Phone**	

EMERGENCY CONTACT

Name		**Relationship**	
Address			
Phone Number		**Cell Phone**	

MEDICAL CONDITIONS

Allergies	

OTHER INFORMATION

In the event that either parent or emergency contact person cannot be contacted by telephone I authorize Xavier Middle Schoo to use discretion and seek medical attention.

****Parent/Guardian Signature**	**Date**

XAVIER MIDDLE SCHOOL ATHLETIC DEPARTMENT
2626 N Oneida St. * Appleton, WI 54911 * (920) 730-8849 * FAX (920) 730-4147

RISK/WAIVER ACKNOWLEDGEMENT FORM

We realize there is a possibility that an athlete may suffer injury, including permanent paralysis or death, as a result of participating in athletic activities.

In light of this information, we the parents/guardians and/or our son/daughter will not hold Xavier Middle School or any of its employees liable for any way for injuries sustained while participating in the interscholastic athletic program offered by Xavier.

Athlete's Full Name: _____
(Please print)

This student will graduate 8th grade with the class of 20_____ .

Signatures: _____ _____
Signature of parent/guardian Date

_____ _____
Signature of student-athlete Date

This form needs the signature of BOTH the parent/guardian and the student-athlete.

THIS FORM IS TO BE COMPLETED JUST ONE TIME AND WILL BE IN EFFECT FOR THE ENTIRE PERIOD WHILE THE STUDENT IS ENROLLED AT XAVIER MIDDLE SCHOOL.

Ascension Medical Group
St. Elizabeth Hospital Campus
1531 S. Madison St., 4th Floor
Appleton, WI 54915

Dear Parent/Guardian,

Ascension Medical Group is currently implementing an innovative program for our student-athletes. This program will assist our team physicians/athletic trainers in evaluating and treating head injuries (e.g., concussion). In order to better manage concussions sustained by our student-athletes, we have acquired a software tool called ImPACT (Immediate Post Concussion Assessment and Cognitive Testing). ImPACT is a computerized exam utilized in many professional, collegiate, and high school sports programs across the country to successfully diagnose and manage concussions. If an athlete is believed to have suffered a head injury during competition, ImPACT is used to help determine the severity of head injury and when the injury has fully healed.

The computerized exam is given to athletes before beginning contact sport practice or competition. This non-invasive test is set up in "video-game" type format and takes about 30-45 minutes to complete. It is simple, and actually many athletes enjoy the challenge of taking the test. Essentially, the ImPACT test is a preseason physical of the brain. It tracks information such as memory, reaction time, speed, and concentration. It, however, is not an IQ test.

If a concussion is suspected, the athlete will be required to re-take the test in a doctor's office. Both the preseason and post-injury test data will help evaluate the injury. The information gathered can also be shared with your family doctor. The test data will enable these health professionals to determine when return-to-play is appropriate and safe for the injured athlete. If an injury of this nature occurs to your child, you will be promptly contacted with all the details.

I wish to stress that the ImPACT testing procedures are non-invasive, and they pose no risks to your student- athlete. We are excited to implement this program given that it provides us the best available information for managing concussions and preventing potential brain damage that can occur with multiple concussions.

Sincerely,

Ascension Medical Group
Providers and Licensed Athletic Trainers

Ascension Medical Group
St. Elizabeth Hospital Campus
1531 S. Madison St., 4th Floor
Appleton, WI 54915

ImPACT Concussion Management Program Participation Agreement

Consent

For use of the Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT)

I have read the attached information. I understand its contents. I have been given an opportunity to ask questions and all questions have been answered to my satisfaction. I agree to participate in the ImPACT Concussion Management Program.

Printed Name of Athlete	
Athlete's Date of Birth	
School (entering)	
Sports Played	

Signature of Athlete _____ Date _____

Signature of Parent _____ Date _____

Parent's Email address _____ Parent Phone Number _____

WISCONSIN STATE LAW REQUIREMENT REGARDING CONCUSSIONS

A state law passed in April 2012, REQUIRES that all athletes and their parents receive educational information regarding the risks of concussion and head injuries and prohibits participation in athletic activity until the athlete and parent has returned a signed agreement sheet indicating that they have read and understand the information. This agreement needs to be turned in only ONCE each school year.

1. Go to the WIAA website: **www.wiaawi.org**
2. Scroll to the bottom under "Coaches" and click on "Concussion Info"
3. Under "Concussion Information" click on "Concussion Forms"
4. Click on "WIAA Condensed Info Form"
5. Both the parent and the athlete must read the information form
6. Once you have read the information form, both the athlete and the parent should sign the reverse side of the form and return the signed form in the folder provided, with the other required paperwork

PARENT & ATHLETE AGREEMENT

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.

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_____

WISCONSIN DEPARTMENT OF PUBLIC INSTRUCTION
125 South Webster Street,
PO Box 7841,
Madison, WI 53707-7841
PHONE 608-266-3390
TOLL FREE 800-441-4563
WEB SITE http://www.dpi.wi.gov

Questions and Contact Information

Name_____Date_____

Address_____

City_____Zip_____County_____

Phone_____Email_____

Age_____ School _____School District_____

Check all that apply
I participate in:

O Football	**O Baseball/Softball**	**O Basketball**	**O Hockey**
O Soccer	**O Golf**	**O Volleyball**	**O Wrestling**
O Track & Field	**O Cross Country**	**O Cheerleading**	**O Skiing/Snowboarding**
O Gymnastics	**O Tennis**	**O Swimming & Diving**	

O 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.

Ascension St. Elizabeth Hospital

A Department of Ascension NE Wisconsin

CONSENT TO ATHLETIC TRAINER SERVICES

I hereby consent to the provision of Athletic Trainer Services for my minor child, _____ by Certified Athletic Trainers of the Ascension NE Wisconsin -Orthopedic and Sports Medicine Department.

I understand these Athletic Trainer Services consist of evaluation of potential injury, recommendations for treatment up to and including emergency medical treatment, and provision of appropriate treatment (exercises, massage, whirlpool, heat or cold, taping and/or splinting of affected areas, use of protective devises).

I understand the Certified Athletic Trainers also advise coaching staff when it is necessary to restrict or limit the participation of my child in athletic activities including practices and official events.

I understand and agree that I am responsible for seeking follow-up care with my own physician or other provider for my child in the event he or she is injured during a sporting event and requires additional medical attention.

I have read and understand the contents of this consent, understand that if I had questions I could contact Kerrie Linsmeyer (920)716-6360, and my questions have been answered to my satisfaction.

I authorize and consent to my minor child's receipt of services from Certified Athletic Trainers of the Ascension Medical Group Orthopedic and Sports Medicine Department.

_____ _____

Parent/Legal Guardian Date

Ascension NE Wisconsin -St. Elizabeth Campus
Ascension Medical Group
1531 South Madison Street
4th Floor Orthopedics
Appleton, Wisconsin 54915