By initialing below I acknowledge that I have received, understand and am in agreement with the following:

Athletes:

Parent	Student	
_____	_____	WIAA High School Athletic Eligibility Information Bulletin
_____		Physical Examination form
		** If we have record of a physical being performed within the last school year, an alternate year card is required. Parents may also choose to have a new physical every year.
_____		I have received and read a copy of the Bellin Health Hippa Form & Privacy Practices.
_____		My emergency contact information may be obtained off of school records and shared with the Coaching staff and/or advisors
_____	_____	Parent & Athlete Concussion Agreement
_____	_____	I have read and understand the provisions of the Co-Curricular Code of Conduct

Activity Members:

Parent	Student	
_____		My emergency contact information may be obtained off of school records and shared with the advisors.
_____	_____	I have read and understand the provisions of the Co-Curricular Code of Conduct

Please Note: ALL pre-participation paperwork must be turned in before the first meeting/practice or you will not be able to participate. No exceptions.

By signing this document, I indicate I have knowledge, understanding and agreement to these standards, set forth in order to be afforded the privilege of being a participant in Wrightstown Co-Curricular activities. I am also aware that any violation on my behalf, to any of these standards, shall result in the consequences contained within the Wrightstown High School Co-Curricular Code of Conduct. I understand the agreement is binding through my graduation from high school.

Student Name Printed: ____

Student Signature: ______________________________________ Date: _________

Parent Signature: _______________________________________ Date: _________

WRIGHTSTOWN MIDDLE SCHOOL

ACTIVITY EMERGENCY CONTACT FORM

Athlete's Name		Date of Birth	
Parents Name			
Address			
Phone Number		Cell Phone	

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

Parents 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	

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 Wrightstown High School to use discretion and seek medical attention/transportation

Parent Signature	Date

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__________________

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.

Revised 4/29/16

CORAUT

HEALTH INFORMATION DISCLOSURE AUTHORIZATION – STUDENT ATHLETE

Full Student Name (First, Middle, and Last) ☐ emancipated minor

Date of Birth

Address

City, State, Zip

Parent's Phone Number

Name of School attended by Student

Anticipated Date of Graduation (month/year)

AUTHORIZES: Bellin Health Licensed Athletic Trainers, Physical Therapists, and Certified Strength and Conditioning Specialists
1970 S. Ridge Road
Green Bay, WI 54304

TO RELEASE: Information concerning my health that impacts my ability to participate in sports or classroom activities. This may include information about injuries (such as, but not limited to, sprains, strains, or concussions), surgeries (such as, but not limited to, ACL reconstruction, rotator cuff repair), test results (such as, but not limited to, MRI or ImPACT results), or medical conditions (such as, but not limited to, asthma).

TO: Officials of the school I attend. This would include all coaching staff, athletic directors, and educational faculty (including school administrators) who are involved in my return to normal academic progression or sporting activities.

THE PURPOSE OF THE RELEASE OF THIS INFORMATION IS:

- To inform the coaching staff and/or educational faculty of my health-related limitations and abilities to continue to participate in sporting events, physical education, and classroom activities.
- To provide the coaching staff and/or educational faculty with information on how to help me safely participate in sporting events, physical education, and the academic environment.

INFORMATION RELEASE FOR CONTINUED CARE: I authorize the release of my medical information for continued medical care, in accordance with federal HIPAA laws.

EXPIRATION DATE OF THIS AUTHORIZATION: If not previously revoked, this authorization will expire on September 1 of the subsequent academic year, or upon graduation or departure from the school system, whichever occurs first.

I have had an opportunity to review and understand the content of this two-sided authorization form. By signing this form, I understand and agree with the content.

Signature of person legally authorized (date/time) to sign for minor student, or signature of the student if his/her age is 18 or greater

If other, indicate relationship:

- ☐ Custodial Parent
- ☐ Court Appointed Guardian
- ☐ Health Care Agent
- ☐ Personal Representative

Printed name of person signing above

I have received a copy of Bellin Health's Notice of Privacy Practices.

Initials

CORAUT

REDISCLOSURE: I understand that School Faculty and/or Coaching Staff are not health care providers, and do not have to follow federal privacy standards. The health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

- **Right to Receive a Copy of this Authorization:** If I agree to sign this authorization, I must be provided with a signed copy of the form.
- **Right to Refuse to Sign this Authorization:** I understand that I am under no obligation to sign this form. If I chose not to sign this form, this may limit my ability to participate in sports because coaching staff need to be made aware of student health issues that impact students' participation in athletic events.
- **Right to Withdraw this Authorization:** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Bellin Health at the address noted above. I realize that if I cancel this authorization, it will not affect disclosures of my information that have already occurred based upon my authorization.

Photocopy/fax copy is as valid as the original.

Note to the student and recipient of information: This disclosed information is protected under Federal Law titled Standards for Privacy of Individually Identifiable Health Information 45 CFR Parts 160 & 164 and by Wisconsin Statute 146.82 and 146.83. Federal regulations prohibit you from making any further disclosure of this information without specific written authorization of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

bellinhealth

Revised 4/29/16

CONSEN

TREATMENT CONSENT – STUDENT ATHLETE

Full Student Name ☐ emancipated minor (First, Middle, and Last)	Date of Birth
Address	City, State, Zip
Parent's Phone Number	
Name of School attended by Student	Anticipated Date of Graduation (month/year)

CONSENT TO TREATMENT: As a result of athletic/school participation, treatment may be necessary for the student. I give consent to Bellin Health Licensed Athletic Trainers, Physical Therapists, and Certified Strength and Conditioning Specialists to evaluate, treat, and manage any injuries, and activate emergency care as indicated within their scope of practice for my child named above. I also give consent to Bellin Health Licensed Athletic Trainers, Physical Therapists, and Certified Strength and Conditioning Specialists to instruct my above named son/daughter in performance enhancing or corrective exercise techniques or programs.

EXPIRATION DATE OF THIS CONSENT: If not previously revoked, this consent will expire on September 1 of the subsequent academic year, or upon graduation or departure from the school system, whichever occurs first.

I have had an opportunity to review and understand the content of this consent form. By signing this form, I understand and agree with the content.

Signature of person legally authorized (date/time)
to sign for minor student, or signature of
the student if his/her age is 18 or greater

If other, indicate relationship:
- ☐ Custodial Parent
- ☐ Court Appointed Guardian
- ☐ Health Care Agent
- ☐ Personal Representative

Printed name of person signing above