

APPENDIX A

KPBSD Athletic/Activity Participation Registration

User Fee Form, Consent Form, Warning, Assumption of Risk, and Hold Harmless Agreement

This form affects your legal rights and responsibilities. Please read it carefully before you sign it and ask questions if there is anything you do not understand.

Eligibility Requirements for students participating in KPBSD and ASAA sponsored activities:

- This form must be complete and on file in the Activities office for **each** sport/club in which the student participates.
- A physical is required every 12 months and cannot expire during the season in which the student is currently participating.
- These forms (Appendix A and physical form) must be on file before the first practice or tryout.
- See attached Appendix B for further requirements including Scholastic Eligibility.

Activities: Place an 'X' next to the activity your student is participating in.

The following activities require a **\$150 participation fee:**

Football Wrestling Ice Hockey Basketball Swimming & Diving Volleyball Nordic Skiing Baseball Softball

The following activities require a **\$100 participation fee:**

Cross Country Running Track & Field Performance Dance Football Cheerleading Basketball Cheerleading Soccer

Requests for refund of fees must be made prior to the first contest. Fees may be prorated due to extenuating circumstances. Students removed from participation for discipline reasons or who quit will not be eligible for a refund. A \$500 annual family limit applies to high school participation fees. Unless waived by the school administration, fees are due prior to the first contest.

- I give my consent for the named KPBSD student to participate in the above named activity.
- I have read the Kenai Peninsula Borough School District activity guidelines (Appendix B) and understand their content.
- I have read and understand the eligibility requirements and code of conduct, including training rules (Appendix B) required of students participating in KPBSD and ASAA sponsored activities.
- I understand the coach may add specific rules and regulations for the activity that he/she supervises.
- I understand the dangers and risks of participating in the named activity range from minor sprains and contusions, to major injuries including concussion, spinal injuries, disfigurement, and injuries that may cause paralysis or even death.
- I understand the possibility a serious injury may impair my abilities to earn a living, to engage in other business, social and recreational activities; and to generally enjoy life.
- I understand the above warnings and recognize the importance of following coaches' instructions regarding playing techniques, training and other team rules and I agree to obey such instructions.
- I understand KPBSD and ASAA will not assume responsibility for injuries sustained in the co-curricular programs. I understand that primary accident insurance coverage is my responsibility.
- If my student is a non-KPBSD alternative education program/homeschool student, I further understand that the KPBSD secondary accident insurance will not cover my student.
- I give my consent to emergency treatment, hospitalization, or other medical treatment as may be necessary by a physician, qualified nurse, emergency medical personnel or hospital in the event of an injury or illness.
- I authorize the school to transport my child to and from KPBSD activities via KPBSD approved transportation.
- I hereby waive on behalf of myself and the participating student named, any liability of the sponsoring high school, KPBSD, or ASAA, or any of its officers, agents or employees for injuries sustained in the co-curricular program.
- I accept financial and legal responsibility of the named student in the event of injury or illness.
- I accept financial and legal responsibility of the named student for property damage, lost equipment and/or disciplinary sanctions.
- I accept the responsibility to pay the cost for transportation should any student be sent home early from an out of town event as a result of their behavior.
- Except for claims arising from sole negligence or willful misconduct of the school district, I hereby agree to hold the KPBSD, its employees, representatives and coaches harmless from any and all liability, actions, debts, or claims of every kind whatsoever which may arise by or in connection with participation of my child/ward in activities related to the above mentioned high school programs. The terms hereof shall serve as a release for my heirs, estate, executor and all members of my family.
- We (student and parent/guardian) consent to abide by the ASAA's rules and regulations, KPBSD's rules and regulations, and my school of eligibility's rules and regulations.

Participant/Student's Printed Name

Student's Signature

Date

Parent/Guardian's Printed Name

Parent/Guardian's Signature

Date

Emergency Contact's Printed Name

Parent/Guard. Phone # (H)

Parent/Guard Phone # (W)

Parent/Guard. Phone # (Cell)

NOTE: If you are a **KPBSD Connections student** or **non-KPBSD alternative education/homeschool student**, you must obtain the signature of your Program Director for each activity you participate in and leave a copy of this form in his/her office.

Program Director Signature

Date

Revised 7/13

STUDENT HEALTH REVIEW/EXAM AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO: **Medical Provider**

I hereby authorize you to release copies of all medical information in your possession, whether paper or electronic, relating to student health review/exams of the student identified below to the school or school district in which the student is enrolled and to appropriate health care providers.

Name of school or school district

This release authorizes disclosure of this information to the school for purposes of the school's determining the fitness of the student to participate in strenuous physical activities, including but not limited to competitive athletic events.

I understand that the medical information disclosed by the medical provider to the school may be further disclosed by the school to the school's administrators, athletic director and coaches of any interscholastic activities in which I seek to participate.

I understand that once the information is disclosed, it may be re-disclosed by the recipient and federal law may not protect the information.

I understand that I may revoke this authorization in writing at any time, except to the extent action has been taken in reliance on this authorization.

I certify that the signatures on this release are voluntary.

Photocopies of this release shall have the same authority as the original. This release will expire one year from the date of signatures on this form, unless revoked earlier by me in writing.

Date of signature

Signature of student

Printed or typed name of student

Student's social security number (optional)

Date of birth

CONSENT OF PARENT

I am the parent or legal guardian of the above student, and authorize the foregoing release of medical information to the student's school/school district and to appropriate health care providers.

Date of signature

Signature of parent / legal guardian

Printed or typed name of parent / legal guardian

STUDENT HEALTH REVIEW/EXAM

SECTION B: To be completed by physician, physician assistant, advanced nurse practitioner or doctor of chiropractic

This form to be sent to the school (do not send to ASAA)

Student Last Name Student First Name MI Date of birth Grade

Height Weight Blood Pressure Pulse

Vision — Right Eye Vision — Left Eye Vision Corrected? Yes No Pupils

| | NORMAL | ABNORMAL FINDINGS | INITIALS |
|-----------------|--------|-------------------|----------|
| Cardiopulmonary | | | |
| Pulse | | | |
| Heart | | | |
| Lungs | | | |
| Skin | | | |
| Abdominal | | | |
| Genitalia | | | |
| Musculoskeletal | | | |
| Neck | | | |
| Shoulder | | | |
| Elbow | | | |
| Wrist | | | |
| Hand | | | |
| Back | | | |
| Knee | | | |
| Ankle | | | |
| Foot | | | |
| Other | | | |

Clearance: Cleared
 Cleared after completed evaluation/rehabilitations for (Specific Sports): _____
 Not cleared for: Collision Contact Noncontact Strenuous
 Moderately Strenuous Nonstrenuous

Due to: _____

Name of M.D., P.A., ANP or DC (circle which) Signature Date

Address Phone

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Play for Keeps

ALASKA SCHOOL ACTIVITIES ASSOCIATION

Student, Parent/Guardian Acknowledgement Form

Please read the following statements, sign below and return to your school's office

- I have participated in ASAA's "Play for Keeps" orientation which includes watching the orientation video.
- I understand the terms of the Tobacco, Alcohol and Controlled Substances Policy as explained during the presentation, including the following penalties for violations.
 - First Offense - 10 days suspension
 - Second Offense - 45 days suspension and additional components
 - Third Offense - 6 months suspension and additional components
 - Fourth Offense - 1 year suspension and additional components

Additional components can be found within the Play for Keeps - Tobacco, Alcohol and Controlled Substances (TAD) Policy.

- I further understand that it is solely the school's responsibility to determine if a violation has occurred and that the school's decision may not be appealed to ASAA.
- I further understand that schools are required to report each violation to ASAA and to maintain strict confidentiality as specified in the policy. More specific wording of the confidentiality statement is found in the policy which is available from the school or at www.asaa.org.
- I further understand that students and parents/guardian must participate in the orientation and sign this form annually as part of the student's eligibility process.
- I further understand that a copy of this signed form must be returned to the school before the student is permitted to participate in interscholastic activities.
- I further understand that schools shall keep a copy of the signed forms on file.
- After participating in the "Play for Keeps" orientation and having the opportunity to review and understand ASAA's Tobacco, Alcohol and Controlled Substances Policy, the violations, penalties and reporting requirements, I agree (both student and parent/legal guardian) to be bound by the terms of the policy.

Printed Name of Student

Student Signature

Date

Printed Name of Parent/Guardian

Parent/Guardian Signature

Date

Sport or Activity

School

STUDENT HEALTH REVIEW/EXAM AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO: **Medical Provider**

I hereby authorize you to release copies of all medical information in your possession, whether paper or electronic, relating to student health review/exams of the student identified below to the school or school district in which the student is enrolled and to appropriate health care providers.

Name of school or school district

This release authorizes disclosure of this information to the school for purposes of the school's determining the fitness of the student to participate in strenuous physical activities, including but not limited to competitive athletic events.

I understand that the medical information disclosed by the medical provider to the school may be further disclosed by the school to the school's administrators, athletic director and coaches of any interscholastic activities in which I seek to participate.

I understand that once the information is disclosed, it may be re-disclosed by the recipient and federal law may not protect the information.

I understand that I may revoke this authorization in writing at any time, except to the extent action has been taken in reliance on this authorization.

I certify that the signatures on this release are voluntary.

Photocopies of this release shall have the same authority as the original. This release will expire one year from the date of signatures on this form, unless revoked earlier by me in writing.

Date of signature

Signature of student

Printed or typed name of student

Student's social security number (optional)

Date of birth

CONSENT OF PARENT

I am the parent or legal guardian of the above student, and authorize the foregoing release of medical information to the student's school/school district and to appropriate health care providers.

Date of signature

Signature of parent / legal guardian

Printed or typed name of parent / legal guardian

STUDENT HEALTH REVIEW/EXAM

SECTION A: To be completed by parent or guardian.

| | | | | |
|--|--|--|--|--|
| Student Last Name | Student First Name | MI | Date of birth | Grade |
| <input style="width:100%;" type="text"/> | <input style="width:100%;" type="text"/> | <input style="width:100%;" type="text"/> | <input style="width:100%;" type="text"/> | <input style="width:100%;" type="text"/> |
| Address | | City | Zipcode | |
| <input style="width:100%;" type="text"/> | | <input style="width:100%;" type="text"/> | <input style="width:100%;" type="text"/> | |
| Phone | Emergency Phone | Date of last physical exam | | |
| <input style="width:100%;" type="text"/> | <input style="width:100%;" type="text"/> | <input style="width:100%;" type="text"/> | | |
| Are your immunizations up to date | Last tetanus shot | Last measles shot | Last TB skin test | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input style="width:100%;" type="text"/> | <input style="width:100%;" type="text"/> | <input style="width:100%;" type="text"/> | |

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Have you ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you presently taking any medications or pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had chest pain during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you tire more quickly than your friends during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever been told that you have a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had racing of your heart or skipped beats? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has anyone in your family died of heart problems or sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you have any skin problems (<i>itching, rashes, acne</i>)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever had a head injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had a concussion? If yes, how many _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever been knocked out or unconscious? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you suffer from migraines? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had a stinger, burner or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever had heat or muscle cramps? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you ever been dizzy or passed out in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have trouble breathing or do you cough during or after activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you use any special equipment (<i>pads, braces, neck rolls, mouth guards, eye guards, etc.</i>)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever had problems with your eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you wear glasses or contacts or protective eye wear? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries in any of the following bones or joints? | <input type="checkbox"/> | <input type="checkbox"/> |
| ___Head ___Shoulder ___Thigh ___Neck ___Elbow ___Knee ___Chest | | |
| ___Forearm ___Shin/calf ___Back ___Wrist ___Ankle ___Hip ___Hand | | |
| 26. Have you ever had other medical problems (<i>infectious mononucleosis, diabetes, etc.</i>)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have you had any medical problem or injury since your last evaluation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Are you Diabetic? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Are you Asthmatic? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Do you have any allergies (<i>medicine, bees or other stinging insects</i>)?? | <input type="checkbox"/> | <input type="checkbox"/> |

List all allergies: _____

31. When was your first menstrual period? _____
 When was your last menstrual period? _____
 What was the longest time between your periods last year? _____
32. Explain all "yes" answers: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct and give consent for my student to be examined.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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STUDENT HEALTH REVIEW/EXAM

SECTION B: To be completed by physician, physician assistant, advanced nurse practitioner or doctor of chiropractic

This form to be sent to the school (do not send to ASAA)

| | | | | |
|--------------------------------------|-------------------------------------|--|---|----------------------|
| Student Last Name [] | Student First Name [] | MI [] | Date of birth [] / [] / [] | Grade [] |
| Height [] | Weight [] | Blood Pressure [] | Pulse [] | |
| Vision — Right Eye 20/ [] | Vision — Left Eye 20/ [] | Vision Corrected? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Pupils [] |

| | NORMAL | ABNORMAL FINDINGS | INITIALS |
|-----------------|--------|-------------------|----------|
| Cardiopulmonary | | | |
| Pulse | | | |
| Heart | | | |
| Lungs | | | |
| Skin | | | |
| Abdominal | | | |
| Genitalia | | | |
| Musculoskeletal | | | |
| Neck | | | |
| Shoulder | | | |
| Elbow | | | |
| Wrist | | | |
| Hand | | | |
| Back | | | |
| Knee | | | |
| Ankle | | | |
| Foot | | | |
| Other | | | |

Clearance: Cleared
 Cleared after completed evaluation/rehabilitations for (Specific Sports): _____
 Not cleared for: Collision Contact Noncontact Strenuous
 Moderately Strenuous Nonstrenuous

Due to: _____

| | | |
|--|-------------------------|--------------------------------|
| Name of M.D., P.A., ANP or DC (circle which) [] | Signature [] | Date [] / [] / [] |
|--|-------------------------|--------------------------------|

| | |
|-----------------------|---------------------|
| Address [] | Phone [] |
|-----------------------|---------------------|

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CONCUSSION INFORMATION PARENT AND STUDENT VERIFICATION

In accordance with AS 14.30.142, the School District requires that each athlete, and each minor athlete's parent/guardian, receive written information on the nature and risks of concussions each year. Students may not participate in school athletic activities unless the student and parent/guardian of a student who is under 18 years of age have signed a current verification that they have received the information provided by the District. Parents will be provided with a pamphlet provided by the Alaska School Activities Association entitled "A Parent's Guide to Concussions in Sports." Students will be provided with a fact sheet produced by the U.S. Dept. of Health and Human Services Centers for Disease Control and Prevention entitled "Head's Up: Concussion in High School Sports – A Fact Sheet for Athletes." Students who are 18 years of age or older will also be provided with the Parent's Guide.

Parents and Students should review this information, discuss it at home, and direct any questions to the student's coach, school principal or athletic activities director.

For more information go to: <http://asaa.org/resources/sports-medicine/>

Student Acknowledgement (required for all athletes)

I acknowledge that I have received a copy of "Head's Up: Concussion in High School Sports – A Fact Sheet for Athletes" and understand its contents.

Student Signature

Print Name

Date

Parent/Guardian/Eligible Student Acknowledgement (Parent signature required for all students under 18 years of age; student signature required for students age 18 or older)

I acknowledge that I have received a copy of "A Parent's Guide to Concussions in Sports" and understand its contents.

Parent/Guardian/Eligible Student Signature

Print Name

Date

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SUDDEN CARDIAC ARREST

PARENT & STUDENT INFORMATION SHEET

Sudden Cardiac Arrest (SCA) takes the lives of thousands of students every year. It is the number one cause of death in student athletes. SCA is where the heart stops beating suddenly. An individual will stop breathing and collapse, lying motionless or appearing to have a seizure.

CAUSES OF SCA INCLUDE:

- Structural heart defects (hypertrophic cardiomyopathy, Marfan syndrome etc.)
- Electrical Heart Defects (long QT syndrome, Wolff-Parkinson White Syndrome, etc.)
- Blow to the chest (Comotio Cordis)

RISK FACTORS FOR SCA INCLUDE:

- Fainting or seizures during or immediately following exercise
- Chests pains during exercise
- Unexplained shortness of breath, long time to catch breath
- Dizziness
- Unusually rapid heart rate
- Extreme fatigue, always tired and lack of energy
- Unexplained sudden death of a direct family member under the age of 50

If you have any of the risk factors consult your healthcare provider

TO INCREASE THE CHANCES OF SURVIVING SCA THERE SHOULD BE:

1. An Emergency Action Plan in place for every practice and event
2. Someone immediately calling 911
3. An Automated External Defibrillator (AED) immediately accessible
4. Cardiopulmonary Resuscitation (CPR) hands only started immediately

I have reviewed and understand the symptoms and warning signs of SCA

TO BE COMPLETED BY THE STUDENT AND HIS/HER PARENT OR GUARDIAN.

Student Name (please print)

Student Signature

Date

Parent or Guardian Name (please print)

Parent or Guardian Signature

Date

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PARENT/GUARDIAN CONSENT FOR STUDENT TRAVEL AND PARTICIPATION

STUDENT

| | | | | |
|--------------------------|---------------------------|----------------------|----------------------|----------------------|
| Student Last Name | Student First Name | MI | Date of birth | Grade |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

| | | |
|----------------------|----------------------|----------------------|
| Address | City | Zipcode |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

| | |
|----------------------|----------------------|
| Phone | Email |
| <input type="text"/> | <input type="text"/> |

| |
|----------------------|
| School |
| <input type="text"/> |

PARENT/GUARDIAN

| | | |
|----------------------------------|-----------------------------------|----------------------|
| Parent/Guardian Last Name | Parent/Guardian First Name | MI |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

| | | |
|----------------------|----------------------|----------------------|
| Address | City | Zipcode |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

| | |
|----------------------|----------------------|
| Phone | Email |
| <input type="text"/> | <input type="text"/> |

COACH/ADVISOR

| | | |
|--------------------------------|---------------------------------|----------------------|
| Coach/Advisor Last Name | Coach/Advisor First Name | MI |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

| | | |
|----------------------|----------------------|----------------------|
| Address | City | Zipcode |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

PRINCIPAL

| | | |
|----------------------------|-----------------------------|----------------------|
| Principal Last Name | Principal First Name | MI |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

| | | |
|----------------------|----------------------|----------------------|
| School | Phone | Email |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

PARENT/GUARDIAN CONSENT FOR STUDENT TRAVEL AND PARTICIPATION

Continuation

CONSENT FOR PARTICIPATION

I hereby give my consent for the above named student to engage in ASAA or school district approved interscholastic activities as a representative of his/her school. I also give my consent for the the above named student to accompany the group as a member on out-of-town trips. I have received and have reviewed the "Parents Guide to Concussion in Sports."

| | | |
|--|--|---|
| Parent/Guardian name (please print) <input style="width: 95%;" type="text"/> | Parent/Guardian signature <input style="width: 95%;" type="text"/> | Date <input style="width: 95%;" type="text"/> |
|--|--|---|

INSURANCE COVERAGE

I understand that the Alaska State Board of Education and Alaska School Activities Association (ASAA) do not carry medical or liability insurance covering students traveling for interscholastic activities. I HEREBY WAIVE ON BEHALF OF MYSELF AND THE ABOVE NAMED STUDENT ANY LIABILITY RESPONSIBILITIES OF THE BOARD OF EDUCATION OR ASAA, EITHER ORGANIZATIONALLY OR FOR ANY OF ITS OFFICERS, AGENTS OR EMPLOYEES, FOR INJURIES OR DAMAGES SUSTAINED IN THE INTERSCHOLASTIC PROGRAM. I also understand that medical or liability insurance is my responsibility.

| | | |
|--|--|---|
| Parent/Guardian name (please print) <input style="width: 95%;" type="text"/> | Parent/Guardian signature <input style="width: 95%;" type="text"/> | Date <input style="width: 95%;" type="text"/> |
|--|--|---|

CONSENT FOR EMERGENCY MEDICAL TREATMENT

In consideration of the above named student's opportunity to participate in interscholastic activities, I hereby give my consent to medical examination, emergency medical treatment, hospitalization or other medical treatment as may be necessary for the welfare of the above named student, by a physician, nurse practitioner, PA, athletic trainer, community health aid, and/or hospital in the event of illness or injury during all periods of time in which the student is away from his or her legal residence as a member of an interscholastic activity group. I further hereby waive on behalf of myself and the above named student, any liability of the school district or ASAA, its officers, agents or employees, arising out of such medical treatment.

Coverage is provided as follows: Native Services Military Private Insurance Carrier
 None. I will assume financial responsibilities for injuries.

Name of Insurer: _____ Policy Number: _____ Phone of Insurer: _____

| | | |
|--|--|---|
| Parent/Guardian name (please print) <input style="width: 95%;" type="text"/> | Parent/Guardian signature <input style="width: 95%;" type="text"/> | Date <input style="width: 95%;" type="text"/> |
|--|--|---|

| | |
|---|---|
| Parent/Guardian phone number <input style="width: 95%;" type="text"/> | Parent/Guardian emergency phone number <input style="width: 95%;" type="text"/> |
|---|---|

| | |
|---|---|
| Personal Physicians Name <input style="width: 95%;" type="text"/> | Personal Physicians phone number <input style="width: 95%;" type="text"/> |
|---|---|

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CONCUSSION INFORMATION

PARENT AND STUDENT VERIFICATION

In accordance with AS 14.30.142, the School District requires that each athlete, and each minor athlete's parent/guardian, receive written information on the nature and risks of concussions each year. Students may not participate in school athletic activities unless the student and parent/guardian of a student who is under 18 years of age have signed a current verification that they have received the information provided by the District. Parents will be provided with a pamphlet provided by the Alaska School Activities Association entitled "A Parent's Guide to Concussions in Sports." Students will be provided with a fact sheet produced by the U.S. Dept. of Health and Human Services Centers for Disease Control and Prevention entitled "Head's Up: Concussion in High School Sports – A Fact Sheet for Athletes." Students who are 18 years of age or older will also be provided with the Parent's Guide.

Parents and Students should review this information, discuss it at home, and direct any questions to the student's coach, school principal or athletic activities director.

For more information go to: <http://asaa.org/resources/sports-medicine/>

Student Acknowledgement (required for all athletes)

I acknowledge that I have received a copy of "Head's Up: Concussion in High School Sports – A Fact Sheet for Athletes" and understand its contents.

Student Signature

Print Name

Date

Parent/Guardian/Eligible Student Acknowledgement

(Parent signature required for all students under 18 years of age; student signature required for students age 18 or older)

I acknowledge that I have received a copy of "A Parent's Guide to Concussions in Sports" and understand its contents.

Parent/Guardian/Eligible Student Signature

Print Name

Date

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