







CHEROKEE COUNTY SCHOOL DISTRICT  
Athletic Parental Consent, Insurance, Authorization and Waiver and Release Form  
2019-20 School Year



STUDENT TRANSPORTATION RELEASE AND CONSENT FORM

While CCSD provides transportation through the utilization of the District bus fleet for many extracurricular events, in some cases school sponsored transportation is not available. In those instances, it is necessary for the parent/guardian to make arrangements for transportation. CCSD discourages students from riding with other students to and from extracurricular events.

I/We, \_\_\_\_\_, parent/guardian of \_\_\_\_\_ (student) hereby give my/our permission for my student to provide his/her own transportation to/from extracurricular events, and I/we, parent/guardian of the student listed above, hereby give my permission for my/our student to ride with another parent.

I/We hereby consent on behalf of the student named to participate in school-sponsored trips. I/We understand that transportation may or may not be provided by CCSD. In the event transportation is not provided by CCSD, transportation will be the student's and parent(s)/guardian(s) responsibility.

\_\_\_\_\_  
Signature(s) Parent(s)/Guardian(s)

\_\_\_\_\_  
Date

RELEASE OF INFORMATION TO MEDIA AND COLLEGES

I/We hereby authorize the release of any and all information relating to the athletic participation of the above-named student to the media and to all college recruiters, including any medical information concerning injury or illness, any biographical information, and any other information related to the athletic participation, including ability, attitude and conduct.

\_\_\_\_\_  
Signature(s) Parent(s)/Guardian(s)

\_\_\_\_\_  
Date

GUIDELINES FOR OUTDOOR EXTRACURRICULAR ACTIVITIES DURING EXTREME HOT AND HUMID WEATHER

I/We hereby verify that I/we have received and reviewed the CCSD Guidelines for Outdoor Extracurricular Activities During Extreme Hot and Humid Weather.

\_\_\_\_\_  
Signature(s) Parent(s)/Guardian(s)

\_\_\_\_\_  
Date

STUDENT ATHLETE CONCUSSION AWARENESS, DIAGNOSIS AND MANAGEMENT PROGRAM

(GHSAA 02.18)

DANGERS OF CONCUSSION

Concussions at all levels of sports have received a great deal of attention and a state law has been passed to address this issue. Adolescent athletes are particularly vulnerable to the effects of concussion. Once considered little more than a minor "ding" to the head, it is now understood that a concussion has the potential to result in death, or changes in brain function (either short-term or long-term). A concussion is a brain injury that results in a temporary disruption of normal brain function. A concussion occurs when the brain is violently rocked back and forth or twisted inside the skull as a result of a blow to the head or body. Continued participation in any sport following a concussion can lead to worsening concussion symptoms, as well as increased risk for further injury to the brain, and even death.

Player and parental education in this area is crucial – that is the reason for this document. Refer to it regularly. This form must be signed by a parent or guardian of each student who wishes to participate in GHSA athletics. One copy needs to be returned to the school, and one retained at home.

COMMONS SIGNS AND SYMPTOMS OF CONCUSSION

- Headache, dizziness, poor balance, moves clumsily, reduced energy level/tiredness
- Nausea or vomiting
- Blurred vision, sensitivity to light and sounds
- Fogginess of memory, difficulty concentrating, slowed thought processes, confused about surroundings or game assignments
- Unexplained changes in behavior and personality
- Loss of consciousness (NOTE: This does not occur in all concussion episodes.)

**BY-LAW 2.68: GHSA CONCUSSION POLICY:** In accordance with Georgia law and national playing rules published by the National Federation of State High School Associations, any athlete who exhibits signs, symptoms, or behaviors consistent with a concussion shall be immediately removed from the practice or contest and shall not return to play until an appropriate health care professional has determined that no concussion has occurred. (NOTE: An appropriate health care professional may include licensed physician (MD/DO) or another licensed individual under the supervision of a licensed physician, such as a nurse practitioner, physician assistant, or certified athletic trainer who has received training in concussion evaluation and management.)



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- a) No athlete is allowed to return to a game or a practice on the same day that a concussion (a) has been diagnosed, OR (b) cannot be ruled out.
- b) Any athlete diagnosed with a concussion shall be cleared medically by an appropriate health care professional prior to resuming participation in any future practice or contest. The formulation of a gradual return to play protocol shall be a part of the medical clearance.

By signing this concussion form, I/we give \_\_\_\_\_ High School permission to transfer this concussion form to the other sports that my child may play. I am aware of the dangers of concussion and this signed concussion form will represent myself and my child during the 2019-2020 school year. This form will be stored with the athletic physical form and other accompanying forms required by CCSD.

I/We have read the information concerning usage of the Immediate Post-Concussion Assessment and Cognitive Test (ImPACT™) and understand its contents. I/We have been given an opportunity to ask questions and all have been answered to my satisfaction. I/We understand that participation in the ImPACT™ concussion baseline testing is highly recommended but not required for athletes in Cherokee County schools. I/We also understand that the ImPACT™ testing is merely a tool to assist Medical Professionals in the diagnosis and subsequent treatment of potentially serious injuries, the ImPACT™ testing IS NOT a substitute for treatment by a Medical Professional.

I/We acknowledge that if my/our child is suspected of receiving a concussion causing injury, my/our child WILL NOT be allowed to participate in athletics until cleared by an appropriate health care provider. (NOTE: An appropriate health care professional may include licensed physician (MD/DO) or another licensed individual under the supervision of a licensed physician, such as a nurse practitioner, physician assistant, or certified athletic trainer who has received training in concussion evaluation and management.)

Please INITIAL one of the choices below, sign and date:

\_\_\_\_\_ YES, I give permission for my child, \_\_\_\_\_, to participate in baseline training with the ImPACT™ program.

\_\_\_\_\_ NO, I do not give permission for my child, \_\_\_\_\_, to participate in baseline testing.

\_\_\_\_\_  
Signature(s) Parent(s)/Guardian(s)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date