Appendix A

Instructions:

To be completed by the parent/guardian and student athlete, and return this signed page to Athletic Department

I give my permission for the sports medicine team (including physicians and certified athletic trainers) in the Cherry Hill Public School District to assess, treat and rehabilitate injuries that may occur to my child as a result of participating in athletics.

I have read and reviewed the school districts Concussion Policy and Guidelines for Return to Competition as well as the Concussion Injury Information fact sheets, Appendix C, provided by Cherry Hill Public School District. I understand the signs and symptoms of concussions (mild traumatic brain injury). And when my demonstrates any of these symptoms, the coach or licensed athletic trainer will remove the child from activity.

I accept the risks associated with my student participating in athletics and I understand the risk associated with my student continuing to participate after sustaining a concussion. I understand it is my or my child's responsibility to inform the School medical staff if he/she is experiencing any signs or symptoms of a concussion.

I understand that only a physician, trained in concussion management, can clear my student to participate after sustaining a concussion and that School District physician may choose not to accept the recommendation of the student's personal physician and can request additional testing or evaluation.

Today's Date: _____ Team/Sport_____

Student's Name: (please print) _____

Signature of Student Athlete _____

Name of Parent/Guardian: (please print)_____

Signature of Parent/Guardian: _____