



Dear Parent/Guardian,

Rittman High School 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 15-20 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. Both the preseason and post-injury test data is given to a local doctor or, to 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. The Rittman High School administration, coaching, and athletic training staffs are striving to keep your child's health and safety at the forefront of the student athletic experience. Please return the attached page with the appropriate signatures. If you have any further questions regarding this program please feel free to contact me at jamie.platz@aultmanorville.org.

Sincerely,

Jamie Platz, ATC



Consent Form

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 _____

Sport _____

Signature of Athlete

Date

Signature of Parent

Date

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PREPARTICIPATION PHYSICAL EVALUATION 2015-2016
THE STUDENT SHALL NOT BE CLEARED TO PARTICIPATE IN INTERSCHOLASTIC ATHLETICS
UNTIL THIS FORM HAS BEEN SIGNED AND RETURNED TO THE SCHOOL



OHSAA AUTHORIZATION FORM 2015-2016

I hereby authorize the release and disclosure of the personal health information of _____ ("Student"), as described below, to _____ ("School").

The information described below may be released to the School principal or assistant principal, athletic director, coach, athletic trainer, physical education teacher, school nurse or other member of the School's administrative staff as necessary to evaluate the Student's eligibility to participate in school sponsored activities, including but not limited to interscholastic sports programs, physical education classes or other classroom activities.

Personal health information of the Student which may be released and disclosed includes records of physical examinations performed to determine the Student's eligibility to participate in school sponsored activities, including but not limited to the Pre-participation Evaluation form or other similar document required by the School prior to determining eligibility of the Student to participate in classroom or other School sponsored activities; records of the evaluation, diagnosis and treatment of injuries which the Student incurred while engaging in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in school sponsored activities.

The personal health information described above may be released or disclosed to the School by the Student's personal physician or physicians; a physician or other health care professional retained by the School to perform physical examinations to determine the Student's eligibility to participate in certain school sponsored activities or to provide treatment to students injured while participating in such activities, whether or not such physicians or other health care professionals are paid for their services or volunteer their time to the School; or any other EMT, hospital, physician or other health care professional who evaluates, diagnoses or treats an injury or other condition incurred by the student while participating in school sponsored activities.

I understand that the School has requested this authorization to release or disclose the personal health information described above to make certain decisions about the Student's health and ability to participate in certain school sponsored and classroom activities, and that the School is not a health care provider or health plan covered by federal HIPAA privacy regulations, and the information described below may be redisclosed and may not continue to be protected by the federal HIPAA privacy regulations. I also understand that the School is covered under the federal regulations that govern the privacy of educational records, and that the personal health information disclosed under this authorization may be protected by those regulations.

I also understand that health care providers and health plans may not condition the provision of treatment or payment on the signing of this authorization; however, the Student's participation in certain school sponsored activities may be conditioned on the signing of this authorization.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by a health care provider in reliance on this authorization, by sending a written revocation to the school principal (or designee) whose name and address appears below.

Name of Principal: _____
School Address: _____

This authorization will expire when the student is no longer enrolled as a student at the school.

NOTE: IF THE STUDENT IS UNDER 18 YEARS OF AGE, THIS AUTHORIZATION MUST BE SIGNED BY A PARENT OR LEGAL GUARDIAN TO BE VALID. IF THE STUDENT IS 18 YEARS OF AGE OR OVER, THE STUDENT MUST SIGN THIS AUTHORIZATION PERSONALLY.

Student's Signature _____ Birth date of Student, including year _____

Name of Student's personal representative, if applicable _____

I am the Student's (check one): Parent Legal Guardian (documentation must be provided)

Signature of Student's personal representative, if applicable _____ Date _____

A copy of this signed form has been provided to the student or his/her personal representative

PREPARTICIPATION PHYSICAL EVALUATION 2015-2016
2015-2016 Ohio High School Athletic Association Eligibility and Authorization Statement

This document is to be signed by the participant from an OHSAA member school and by the participant's parent.

I have read, understand and acknowledge receipt of the **OHSAA Student Athlete Eligibility Guide** which contains a summary of the eligibility rules of the Ohio High School Athletic Association. I understand that a copy of the *OHSAA Handbook* is on file with the principal and athletic administrator and that I may review it, in its entirety, if I so choose. All OHSAA bylaws and regulations from the *Handbook* are also posted on the OHSAA website at ohsaa.org.

I understand that an OHSAA member school must **adhere to all rules and regulations** that pertain to the interscholastic athletics programs that the school sponsors, but that local rules may be more stringent than OHSAA rules.

I understand that participation in interscholastic athletics is a **privilege not a right**.

Student Code of Responsibility

As a student athlete, I **understand and accept** the following responsibilities:

I will **respect the rights and beliefs** of others and will treat others with courtesy and consideration.

I will be **fully responsible** for my own actions and the consequences of my actions.

I will **respect the property** of others.

I will **respect and obey the rules** of my school and laws of my community, state and country.

I will **show respect to those who are responsible for enforcing the rules** of my school and the laws of my community, state and country.

I **understand that a student whose character or conduct violates** the school's Athletic Code or School Code of Responsibility is not in good standing and is ineligible for a period of time as determined by the principal.

Informed Consent – By its nature, participation in interscholastic athletics includes risk of injury and transmission of infectious disease such as HIV and Hepatitis B. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants have a responsibility to help reduce that risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, GUARDIANS OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN AN OHSAA-SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN'S SIGNATURE.**

I understand that in the case of **injury or illness requiring treatment by medical personnel and transportation to a health care facility**, that a reasonable attempt will be made to contact the parent or guardian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be treated and transported via ambulance to the nearest hospital.

I **consent to medical treatment** for the student following an injury or illness suffered during practice and/or a contest.

To enable the OHSAA to determine whether the herein named student is eligible to participate in interscholastic athletics in an OHSAA member school I **consent to the release to the OHSAA any and all portions of school record files**, beginning with seventh grade, of the herein named student, specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, academic work completed, grades received and attendance data.

I **consent to the OHSAA's use of the herein named student's name**, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.

I **understand that if I drop a class**, take course work through Post Secondary Enrollment Option, Credit Flexibility or other educational options, this action could affect compliance with OHSAA academic standards and my eligibility.

I **understand all concussions are potentially serious** and may result in complication, including prolonged brain damage and death if not recognized and managed properly. Further I understand that if my student is removed from a practice or competition due to a suspected concussion, he or she will be unable to return to participation that day. After that day written authorization from a physician (M.D. or D.O.) or an athletic trainer working under the supervision of a physician will be required in order for the student to return to participation.

I **have read and signed** the Ohio Department of Health's **Concussion Information Sheet** and have retained a copy for myself.

By signing this we acknowledge that we have read the above information and that we consent to the herein named student's participation.

***Must Be Signed Before Physical Examination**

Student's Signature

Birth date

Grade in School

Date

Parent's or Guardian's Signature

Date

Rittman Exempted Village School District
EMERGENCY MEDICAL AUTHORIZATION

Student's Legal Name _____
Home Address _____
City, State & Zip Code _____ Phone (____) _____
Date of Birth ____ / ____ / ____ Grade _____ Teacher _____

RESIDENTIAL PARENT/GUARDIAN INFORMATION

(The purpose of this information is to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parent or guardians cannot be reached.)

Mother _____	Daytime Phone (____) _____
Father _____	Daytime Phone (____) _____
Relative / Childcare Provider _____	Relationship _____
Address _____	Phone (____) _____
Other Contact _____	Phone (____) _____
Doctor _____	Phone (____) _____
Dentist _____	Phone (____) _____
Medical Specialist _____	Phone (____) _____
Local Hospital _____	Phone (____) _____

TO GRANT CONSENT

In the event reasonable attempts to contact me or the other parent or guardian have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the listed doctor, dentist, or medical professionals, or, in the event the designated preferred practitioner is not available, by a licensed physician or dentist; and (2) the transfer of the child to the above hospital or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

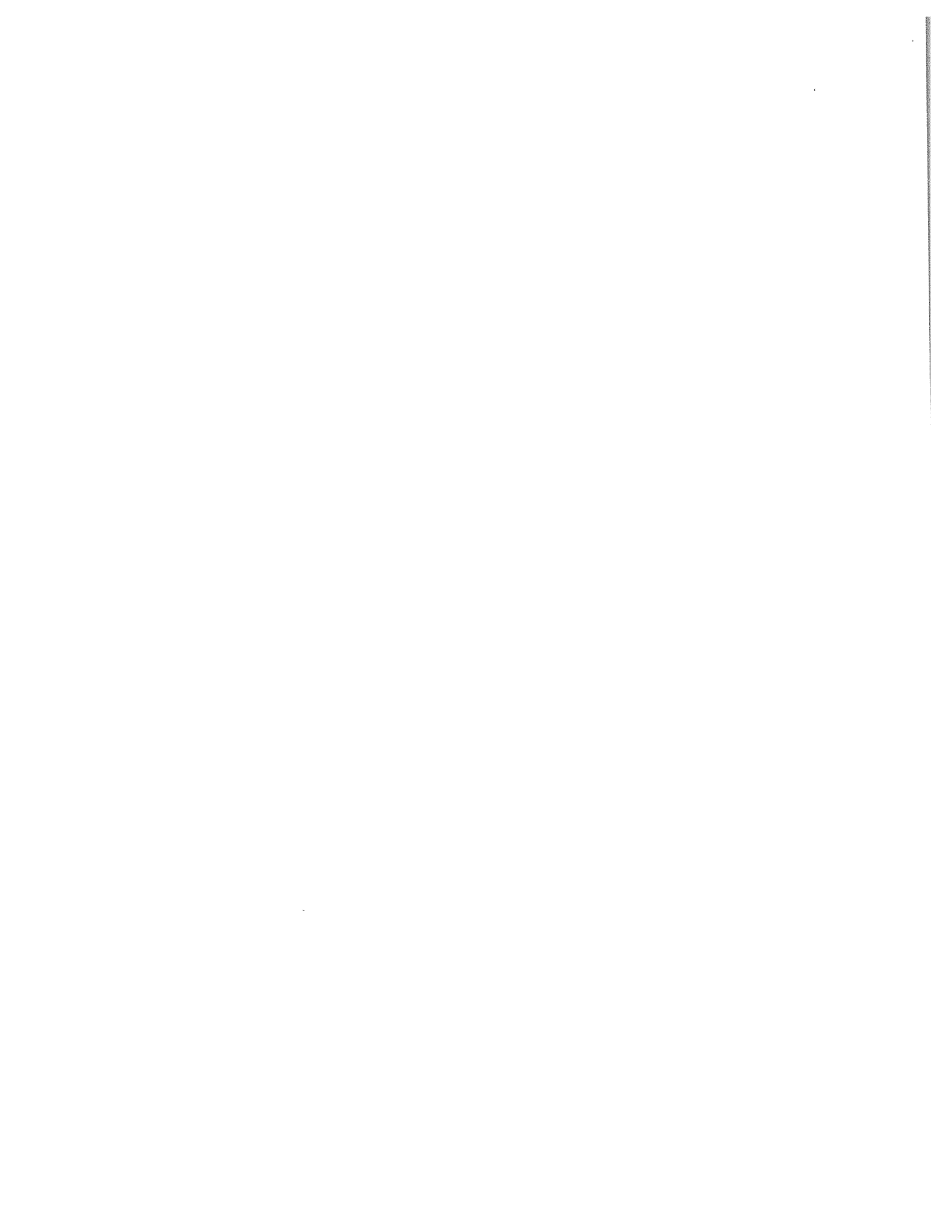
Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted are: _____

Date _____ Signature of Parent or Guardian _____

REFUSAL TO GRANT CONSENT

DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Date _____ Signature of Parent or Guardian _____



Participant Responsibility Creed

As a Rittman school program participant, I recognize that I represent Rittman Schools, acknowledge the honor, publicity, and awards that may come to me, and accept the responsibility and specific rules that go hand in hand with activity participation.

I fully understand that I represent my school and community at all times and pledge to do my best to promote a positive impression of myself, my activity, my school, and community.



*To violate this creed is to forfeit the
privilege to participate.*

Expect the best!

I represent the Rittman Indians

Responsibility



Recognition

Student Name (Please Print)

Student Signature

Parent Signature

Participation responsibility and training rules are to be adhered to, by the athlete, in and out of season, 365 days a year.

