Independent School District No.1
Lewiston, Idaho

STUDENT ATHLETE
ACKNOWLEDGEMENT OF RECEIPT OF CONCUSSION GUIDELINES

NOTE: Both signature lines below must be completed and this form must be provided to the District prior to the student athlete participating in any school athletic leagues or sports.

Parent/Guardian Signature Required:

I, (print parent/guardian name)_____, acknowledge that I am the parent or guardian of the student (below), that I have received from the District information related to student athlete concussions, including information from the State Department of Education, the Idaho High School Activities Association, and District Rules and Regulations 5120, and have had the opportunity to review and have reviewed such information. I understand that participation in school athletic leagues or sports is dangerous, and hereby agree to waive all liability against Lewiston Independent School District No.1, its employees, agents and trustees, related to any injury or damages that my student may experience or incur as a result of participation in such school athletic leagues or sports.

_____ _____
Signature Date

Student Signature Required:

I, (print student name)_____, acknowledge that I am a student of Lewiston Independent School No.1, or otherwise am allowed to participate in school athletic leagues or sports, that I have received from the District information related to student athlete concussions, including information from the State Department of Education, the Idaho High School Activities Association, and District Rules and Regulations 5120, and have had the opportunity to review and have reviewed such information. I understand that participation in school athletic leagues or sports is dangerous, and accept the risk of the potential consequences of such dangers.

_____ _____
Signature Date

THIS FORM IS ONLY NECESSARY AFTER YOU HAVE BEGUN CONCUSSION PROTOCOL

Independent School District No. 1
Lewiston, Idaho

PHYSICIAN AUTHORIZATION TO RETURN TO PLAY OR PARTICIPATE IN STUDENT SPORTS

I hereby state that I am a:

____ Physician licensed pursuant to Chapter 18, Title 54, Idaho Code.

____ Physician assistant licensed pursuant to Chapter 18, Title 54, Idaho Code.

____ Advanced practice nurse licensed under Section 54-1409, Idaho Code.

____ A licensed health care professional trained in the evaluation and management of concussions who is supervised by a directing physician licensed under Chapter 18, Title 54, Idaho Code. My directing physician is _____, and his/her license number is _____, and address is_____.

I further state that I have met with_____(hereinafter referred to as "student athlete") to evaluate the student athlete for a concussion. I have discussed with the student athlete the potential ramifications of continuing to play sports after having received a concussion or exhibiting concussion-like symptoms. I am satisfied that the student athlete can return to play and/or participate in school athletic leagues or sports without significant likelihood of danger or injury, and I therefore authorize student athlete to return to play and/or participation in school athletic leagues or sports.

_____ _____ _____
Signature Date License No.

_____
Address

_____ _____
Signature of Directing Physician Date
(if signed by a Licensed Health Care Professional)