DAKOTA HIGH SCHOOL ATHLETIC DEPARTMENT

Athletic Code of Conduct can be viewed at www.dakotacougars.com

CODE OF CONDUCT ACKNOWLEDGEMENT FORM FOR STUDENT ATHLETES AND PARENTS

TO BE COMPLETED ONE TIME PER ATHLETIC CAREER

Complete Legal Name of Student: _____

Date of Birth: _____/_____/_____ **School:** [] Dakota High School [] Iroquois Middle School [] Seneca Middle School

Athlete's Graduation Year - (circle) 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022

HAS THIS STUDENT ATTENDED A HIGH SCHOOL OR MIDDLE SCHOOL OTHER THAN THE ONE LISTED ABOVE? Yes No
IF YES, Name of School and School Year that student attended:
School: _____ **School Year:** _____

I HEREBY GIVE MY CONSENT FOR THE STUDENT NAMED ABOVE TO ENGAGE IN INTERSCHOLASTIC ATHLETICS AND UNDERSTAND THE POSSIBILITY THAT SERIOUS INJURY MAY RESULT FROM PARTICIPATING IN ATHLETIC ACTIVITIES. I FURTHER UNDERSTAND THAT THE ABOVE STUDENT WILL BE EXPECTED TO ADHERE FIRMLY TO ALL ESTABLISHED ATHLETIC POLICIES OF THE SCHOOL DISTRICT AND THE MICHIGAN HIGH SCHOOL ATHLETIC ASSOCIATION. I RECOGNIZE THAT AS A RESULT OF ATHLETIC PARTICIPATION, MEDICAL TREATMENT ON AN EMERGENCY BASIS MAY BE NECESSARY AND FURTHER RECOGNIZES THAT SCHOOL PERSONNEL MAY BE UNABLE TO CONTACT ME FOR MY CONSENT FOR EMERGENCY MEDICAL CARE. I DO HEREBY CONSENT IN ADVANCE TO SUCH EMERGENCY CARE, INCLUDING HOSPITAL CARE, AS MAY BE DEEMED NECESSARY UNDER THE THEN EXISTING CIRCUMSTANCES AND TO ASSUME RESPONSIBILITY FOR THE EXPENSES OF SUCH CARE. I AUTHORIZE CHIPPEWA VALLEY SCHOOLS TO USE A PHOTOGRAPH OR VIDEO RECORDING OF MY CHILD FOR DISTRICT NEWS OR WEB PAGE PUBLICATIONS. MY SIGNATURE ACKNOWLEDGES THAT I HAVE READ THIS ENTIRE DOCUMENT AND I AGREE ON BEHALF OF THE ABOVE NAMED STUDENT AND MYSELF TO ABIDE BY ALL OF ITS PROVISIONS.

SIGNATURE OF PARENT/GUARDIAN: _____ **Date:** _____/_____/_____

AS AN ATHLETE, I UNDERSTAND THAT I AM EXPECTED TO ADHERE FIRMLY TO ALL ESTABLISHED ATHLETIC POLICIES OF DAKOTA HIGH SCHOOL, CHIPPEWA VALLEY SCHOOL DISTRICT, AND THE MICHIGAN HIGH SCHOOL ATHLETIC ASSOCIATION SUCH AS THOSE STATED IN THIS DOCUMENT. MY SIGNATURE ACKNOWLEDGES THAT I HAVE READ THE ENTIRE ATHLETIC CODE OF CONDUCT, UNDERSTAND THAT IT IS IN EFFECT 365 DAYS A YEAR, ALL DAY, EVERYDAY, AND EVERYWHERE, AND I AGREE TO ABIDE BY ALL OF THE STATED POLICIES, PROCEDURES, AND CODES OF THE ATHLETIC DEPARTMENT. I ALSO UNDERSTAND THAT THERE ARE ADDITIONAL POLICIES I MUST ADHERE TO WHICH ARE NOT CONTAINED IN THIS DOCUMENT.

SIGNATURE OF ATHLETE: _____ **Date:** _____/_____/_____

DAKOTA HIGH SCHOOL ATHLETIC DEPARTMENT

IMPACT TEST ACKNOWLEDGEMENT FOR STUDENT ATHLETES AND PARENTS

Dakota High School and Chippewa Valley Schools are 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). Student Athletes are required to take an ImPACT Test. 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 practices and or 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. 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 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.

I give my permission for the student athlete named above to take an ImPACT Test. I understand that my child may need to be tested more than once, depending upon the results of the test, as compared to my child's baseline test, which will be on file. I understand there is no charge for the testing at Dakota HS. I understand that there may be charges incurred by follow up care.

Printed Name of Parent or Guardian: _____

Signature of Parent or Guardian: _____ **Date:** _____/_____/_____

Cell Number: _____-_____-_____ **Email Address:** _____