



## EMERGENCY MEDICAL AUTHORIZATION

**Purpose** – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached. This information may be shared with the educational team to best meet your child's needs.

Student Name \_\_\_\_\_  
Address \_\_\_\_\_

Phone # \_\_\_\_\_ Bus # N/A

Health Insurance Provider \_\_\_\_\_

Plan Number \_\_\_\_\_

Address Change Y ☐ N ☐ Birth Date \_\_\_\_\_

Sex M ☐ F ☐ Grade \_\_\_\_\_ Home Room N/A

### Residential Parent or Guardian:

**\*\*Email:** \_\_\_\_\_

Mother \_\_\_\_\_ Day Ph # \_\_\_\_\_ Cell # \_\_\_\_\_

Father \_\_\_\_\_ Day Ph # \_\_\_\_\_ Cell # \_\_\_\_\_

Other Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Ph # \_\_\_\_\_

Other Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Ph # \_\_\_\_\_

**I hereby give consent for the following medical care providers and local hospital to be called:**

Doctor \_\_\_\_\_

Phone # \_\_\_\_\_

Dentist \_\_\_\_\_

Phone # \_\_\_\_\_

Medical Specialist \_\_\_\_\_

Phone # \_\_\_\_\_

Hospital \_\_\_\_\_

Phone # \_\_\_\_\_

**Check below any CURRENT health condition that may require attention during the school day:**

☐ Allergies (be specific)

☐ Other health conditions (be specific) \_\_\_\_\_

☐ Food \_\_\_\_\_ EpiPen ☐ Yes ☐ No

☐ Previous surgeries (include date) \_\_\_\_\_

☐ Medicine \_\_\_\_\_

☐ Bee sting \_\_\_\_\_ EpiPen ☐ Yes ☐ No

☐ Previous concussion/head injury – year \_\_\_\_\_

☐ Other \_\_\_\_\_

☐ Hearing problems Has hearing aids ☐ Yes ☐ No

☐ Asthma Uses emergency inhaler ☐ Yes ☐ No

☐ Vision problems (be specific) \_\_\_\_\_

Inhaler will be at school ☐ Yes ☐ No

Wears: ☐ Glasses ☐ Contacts

☐ Cancer

☐ ADHD

☐ Diabetes

☐ Behavior/emotional problems \_\_\_\_\_

☐ Seizures

☐ Heart problems (be specific) \_\_\_\_\_

☐ Bleeding Disorder

☐ Physical disability (be specific) \_\_\_\_\_

☐ **NO CURRENT HEALTH CONDITIONS**

☐ **List all medications and dosages your child receives on a continual basis:** \_\_\_\_\_

## PLEASE COMPLETE PART I OR PART II NOT BOTH

### Part I – TO GRANT CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by the designated physician or dentists, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to the designated hospital or any hospital reasonably accessible.

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

Date \_\_\_\_\_ Parent or Guardian Signature \_\_\_\_\_

### Part II – REFUSAL TO CONSENT (Refusal to consent may be grounds for non-participation)

I 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 no action or to: \_\_\_\_\_

Date \_\_\_\_\_ Parent or Guardian REFUSAL Signature \_\_\_\_\_

**WALSH UNIVERSITY**  
**LIABILITY RELEASE, WAIVER, DISCHARGE AND AGREEMENT NOT TO SUE**

For Minor Participation (Gr. K -12)

1. I desire that my child \_\_\_\_\_ participate in the following activity/trip \_\_\_\_\_ ("Activity"), to be held on \_\_\_\_\_. I fully understand and appreciate the dangers, hazards, and risks inherent in the Activity, in the transportation to and from the Activity (if applicable), and in any activities undertaken supplemental to the Activity. These dangers and risks can result in injury and impairment to my body, general health, well being, and could include serious or even mortal injuries and property damage.
2. Knowing the dangers, hazards, and risks of such activities, and in consideration of being permitted to participate in the Activity, on behalf of myself, my family, heirs, and personal representative(s), I agree to assume all the risks and responsibilities surrounding my child's participation in the Activity, the transportation, and in any activities undertaken as supplemental and to release, waive, forever discharge, and covenant not to sue Walsh University, and its governing board, officers, agents, employees and any students acting as employees ("Releasees"), from and against any and all liability for any harm, injury, damage, claims, demands, actions, causes of action, costs, and expenses of any nature that I may have or that may hereafter accrue to me, arising out of or related to any loss, damage, or injury, including but not limited to suffering and death, that may be sustained by my child or by any property belonging to my child, whether caused by the negligence or carelessness of the Releasees, or otherwise, while in, on, upon, or in transit to or from the premises where the Activity, or any supplement to the Activity, occurs or is being conducted.
3. I understand and agree that Releasees are granted permission to authorize emergency medical treatment, if necessary, and that such action by Releasees shall be subject to the terms of this Agreement. I understand and agree that Releasees assume no responsibility for any injury or damage which might arise out of or in connection with such authorized emergency medical treatment.
4. It is my express intent that this release and hold harmless agreement shall bind myself, the members of my family and spouse, if I am alive, and my estate, family, heirs, administrators, personal representatives, or assigns, if I am deceased, and shall be deemed as a "Release, Waiver, Discharge and Covenant" not to sue the Releasees.
5. In signing this Release, I acknowledge and represent that I have carefully read this Agreement and understand its contents and that I sign this document as my own free act and deed. I further state that I am an adult and fully competent to sign this Agreement; and that I execute this release for full, adequate, and complete consideration fully intending to be bound by the same. I further state that there are no health-related reasons or problems which preclude or restrict my child's participation in this activity, and that I have adequate health insurance necessary to provide for and pay any medical costs that may be attendant as a result of injury to my child.
6. I further agree that this Release shall be construed in accordance with the laws of the State of Ohio. If any term or provision of this Release shall be held illegal, unenforceable, or in conflict with any law governing this Release the validity of the remaining portions shall not be affected thereby.
7. MEDIA RELEASE: I grant \_\_\_\_ or deny \_\_\_\_ permission to Walsh University to use my child's photos, video recordings, audiotapes, digital images, and the like taken or made on behalf of Walsh University.

THIS IS A RELEASE OF LEGAL RIGHTS. READ AND BE CERTAIN YOU UNDERSTAND IT BEFORE SIGNING. Signature of

Parent or

Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

# Ohio Department of Health Concussion Information Sheet

## For Interscholastic Athletics

Dear Parent/Guardian and Athletes,

This information sheet is provided to assist you and your child in recognizing the signs and symptoms of a concussion. Every athlete is different and responds to a brain injury differently, so seek medical attention if you suspect your child has a concussion. Once a concussion occurs, it is very important your athlete return to normal activities slowly, so he/she does not do more damage to his/her brain.

### What is a Concussion?

A concussion is an injury to the brain that may be caused by a blow, bump, or jolt to the head. Concussions may also happen after a fall or hit that jars the brain. A blow elsewhere on the body can cause a concussion even if an athlete does not hit his/her head directly. Concussions can range from mild to severe, and athletes can get a concussion even if they are wearing a helmet.

### Signs and Symptoms of a Concussion

Athletes do not have to be “knocked out” to have a concussion. In fact, less than 1 out of 10 concussions result in loss of consciousness. Concussion symptoms can develop right away or up to 48 hours after the injury. Ignoring any signs or symptoms of a concussion puts your child’s health at risk!

#### Signs Observed by Parents of Guardians

- ◆ *Appears dazed or stunned.*
- ◆ *Is confused about assignment or position.*
- ◆ *Forgets plays.*
- ◆ *Is unsure of game, score or opponent.*
- ◆ *Moves clumsily.*
- ◆ *Answers questions slowly.*
- ◆ *Loses consciousness (even briefly).*
- ◆ *Shows behavior or personality changes (irritability, sadness, nervousness, feeling more emotional).*
- ◆ *Can’t recall events before or after hit or fall.*

#### Symptoms Reported by Athlete

- ◆ *Any headache or “pressure” in head. (How badly it hurts does not matter.)*
- ◆ *Nausea or vomiting.*
- ◆ *Balance problems or dizziness.*
- ◆ *Double or blurry vision.*
- ◆ *Sensitivity to light and/or noise*
- ◆ *Feeling sluggish, hazy, foggy or groggy.*
- ◆ *Concentration or memory problems.*
- ◆ *Confusion.*
- ◆ *Does not “feel right.”*
- ◆ *Trouble falling asleep.*
- ◆ *Sleeping more or less than usual.*

### Be Honest

Encourage your athlete to be honest with you, his/her coach and your health care provider about his/her symptoms. Many young athletes get caught up in the moment and/or feel pressured to return to sports before they are ready. It is better to miss one game than the entire season... or risk permanent damage!

### Seek Medical Attention Right Away

Seeking medical attention is an important first step if you suspect or are told your child has a concussion. A qualified health care professional will be able to determine how serious the concussion is and when it is safe for your child to return to sports and other daily activities.

- ◆ *No athlete should return to activity on the same day he/she gets a concussion.*
- ◆ *Athletes should **NEVER** return to practices/games if they still have ANY symptoms.*
- ◆ *Parents and coaches should never pressure any athlete to return to play.*

### The Dangers of Returning Too Soon

Returning to play too early may cause Second Impact Syndrome (SIS) or Post-Concussion Syndrome (PCS). SIS occurs when a second blow to the head happens before an athlete has completely recovered from a concussion. This second impact causes the brain to swell, possibly resulting in brain damage, paralysis, and even death. PCS can occur after a second impact. PCS can result in permanent, long-term concussion symptoms. The risk of SIS and PCS is the reason why no athlete should be allowed to participate in any physical activity before they are cleared by a qualified health care professional.

### Recovery

A concussion can affect school, work, and sports. Along with coaches and teachers, the school nurse, athletic trainer, employer, and other school administrators should be aware of the athlete’s injury and their roles in helping the child recover.

During the recovery time after a concussion, physical and mental rest are required. A concussion upsets the way the brain normally works and causes it to work longer and harder to complete even simple tasks. Activities that require concentration and focus may make symptoms worse and cause the brain to heal slower. Studies show that children’s brains take several weeks to heal following a concussion.



[www.healthyohioprogram.gov/vipp/concussion](http://www.healthyohioprogram.gov/vipp/concussion)



## What is a Concussion?

1. Be sure your child gets plenty of rest and enough sleep at night – no late nights. Keep the same bedtime weekdays and weekends.
2. Encourage daytime naps or rest breaks when your child feels tired or worn-out.
3. Limit your child's activities that require a lot of thinking or concentration (including social activities, homework, video games, texting, computer, driving, job-related activities, movies, parties). These activities can slow the brain's recovery.
4. Limit your child's physical activity, especially those activities where another injury or blow to the head may occur.
5. Have your qualified health care professional check your child's symptoms at different times to help guide recovery.

## Returning to School

1. Your athlete may need to initially return to school on a limited basis, for example for only half-days, at first. This should be done under the supervision of a qualified health care professional.
2. Inform teacher(s), school counselor or administrator(s) about the injury and symptoms. School personnel should be instructed to watch for:
  - a. Increased problems paying attention.
  - b. Increased problems remembering or learning new information.
  - c. Longer time needed to complete tasks or assignments.
  - d. Greater irritability and decreased ability to cope with stress.
  - e. Symptoms worsen (headache, tiredness) when doing schoolwork.
3. Be sure your child takes multiple breaks during study time and watch for worsening of symptoms.
4. If your child is still having concussion symptoms, he/she may need extra help with school-related activities. As the symptoms decrease during recovery, the extra help or supports can be removed gradually.

### Resources

ODH Violence and Injury Prevention Program  
[www.healthyohioprogam.org/vipp/injury.aspx](http://www.healthyohioprogam.org/vipp/injury.aspx)

Centers for Disease Control and Prevention  
[www.cdc.gov/Concussion](http://www.cdc.gov/Concussion)

National Federation of State High School Associations  
[www.nfhs.org](http://www.nfhs.org)

Brain Injury Association of America  
[www.biausa.org/](http://www.biausa.org/)

## Returning to Play

1. Returning to play is specific for each person, depending on the sport. *Ohio law requires written permission from a health care provider before an athlete can return to play.* Follow instructions and guidance provided by a health care professional. It is important that you, your child and your child's coach follow these instructions carefully.
2. Your child should NEVER return to play if he/she still has ANY symptoms. (Be sure that your child does not have any symptoms at rest and while doing any physical activity and/or activities that require a lot of thinking or concentration).
3. Be sure that the athletic trainer, coach and physical education teacher are aware of your child's injury and symptoms.
4. Your athlete should complete a step-by-step exercise-based progression, under the direction of a qualified healthcare professional.
5. A sample activity progression is listed below. Generally, each step should take no less than 24 hours so that your child's full recovery would take about one week once they have no symptoms at rest and with moderate exercise.\*

### Sample Activity Progression\*

**Step 1:** Low levels of non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: walking, light jogging, and easy stationary biking for 20-30 minutes).

**Step 2:** Moderate, non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: moderate jogging, brief sprint running, moderate stationary biking, light calisthenics, and sport-specific drills without contact or collisions for 30-45 minutes).

**Step 3:** Heavy, non-contact physical activity, provided NO SYMPTOMS return during or after activity. (Examples: extensive sprint running, high intensity stationary biking, resistance exercise with machines and free weights, more intense non-contact sports specific drills, agility training and jumping drills for 45-60 minutes).

**Step 4:** Full contact in controlled practice or scrimmage.

**Step 5:** Full contact in game play.

\*If any symptoms occur, the athlete should drop back to the previous step and try to progress again after a 24 hour rest period.



**Ohio Department of Health**  
Violence and Injury Prevention Program  
246 North High Street, 8th Floor  
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(614) 466-2144

[www.healthyohioprogam.gov/vipp/concussion](http://www.healthyohioprogam.gov/vipp/concussion)

# Ohio Department of Health Concussion Information Sheet

## *For Interscholastic Athletics*

I have read the Ohio Department of Health's Concussion Information Sheet and understand that I have a responsibility to report my/my child's symptoms to coaches, administrators and health care provider.

I also understand that I/my child must have no symptoms before return to play can occur.

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Athlete

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Date



Rev. 01.13

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Athlete

*Please print name*

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Parent/Guardian

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Date

*Signature*

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Parent/Guardian

*Please print name*