



## CONCUSSION RECOGNITION AGREEMENT & LIABILITY WAIVER

Participant Name: \_\_\_\_\_ Age: \_\_\_\_\_

Program: \_\_\_\_\_

Has your child ever had a concussion? \_\_\_\_\_ If yes, how many? \_\_\_\_\_

Has your child ever experienced concussion symptoms? \_\_\_\_\_ Did you report them? \_\_\_\_\_

**As a Parent of an athlete it is important to recognize the signs, symptoms, and behaviors of concussions.**

By signing this form you are stating that you understand the importance of recognizing and responding to the signs, symptoms, and behaviors of a concussion or head injury. This form must be completed for every program athletes are involved with. The ABCs of Concussions is included with this form. It is your responsibility as a parent to read the information carefully before signing this waiver.

Parents/guardians are required to sign for minors.

I, the undersigned, do hereby agree to allow my child to participate in the activity indicated. I am aware of and understand that there may be potential risks inherent with participating in any recreation activity and that the City of West Bend does not provide accident insurance. I assume all risks and hazards incidental to such participation and do hereby waive, release, absolve, indemnify and agree to hold harmless the City of West Bend, its officers, employees and volunteers from any and all claims, injuries, liability, damages or right of action directly or indirectly arising out of use of and/or participation in this recreational activity.

In the event of medical emergency, I authorize West Bend Parks, Recreation & Forestry Department staff to obtain medical treatment for my son/daughter and agree to be responsible for the costs thereof.

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**PARENT/GUARDIAN AGREEMENT:**

I, \_\_\_\_\_, have read the Parent Concussion and Head injury information along with the liability waiver and understand what a concussion is and how it may be caused. I agree that my child must be removed from practice/play if a concussion is suspected.

- I also understand the common signs, symptoms, and behaviors of a concussion
- I understand that it is my responsibility to seek medical treatment if a suspected concussion is reported to me
- I understand that my child must be removed from practice/play if a concussion is suspected and cannot return to practice/play until providing written clearance from an appropriate health care provider to his/her coach and to our department
- I understand the possible consequences of my child returning to practice/play too soon.

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_