KAUKAUNA CATHOLIC SCHOOL ATHLETIC ASSOCIATION- CONTACT INFORMATION

Related to Concussion Law 2011 – Wisconsin Act 172

Each student participating in any KCSS athletic program must have this form completed.

******************IN CASE OF INJURY, ACCIDENT OR EMERGENCY*******************

Athletes Full Name: _____
Age: _____ School: KCSS

Parents/Guardian Full Names
_____
_____

Email: _____

Phone Numbers: _____ home
_____work _____ cell
Address: _____

EMERGENCY CONTACT
Name _____ Relationship _____ Phone Number _____

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1. Has your child ever had a concussion? _____ If yes, how many? _____
2. Has your child ever experienced concussion symptoms? _____ Did you report them?_____

As a parent or Guardian of _____ I give my permission to have the coach(es) call for medical attention to the nearest physician or hospital in case of accident or injury.

The coaches/gym supervisor have my permission to administer first aid to the best of their ability:_____yes _____no.

Hospital Preference: _____

Family Doctor Name: _____ Phone: _____

Family Dentist Name: _____ Phone: _____

Known Allergies to Drugs or Anesthetics:
_____
_____
_____

_____ _____
Parent's/Guardian Signature Date