Concussion Protocol
Parent/Guardian AcknowledgementForm

Season: _____ Program: _____

Athlete Name: _____

Level of Play: _____

1. I understand that the California Amateur Hockey Association has adopted concussion-related education, awareness and protocol into their policies and procedures.

2. I understand the following guidelines and protocol exist, and will respect them if they must be instituted with the above-named athlete:
   a. An athlete who is suspected of sustaining a concussion or head injury shall be immediately removed from participation for the remainder of the day. Removal can be at the request of a coach, official, team manager, parent/guardian, or the athlete.
   b. Athlete shall not be permitted to return to participation until he/she is evaluated and released by a medical professional trained in the management of concussions and acting within the scope of his/her practice. Acceptable evaluators should be medical professionals with one of the following medical license designations: MD, DO, Neurologist, Neuropsychologist.
   c. The athlete shall not be permitted to return to participation until he or she provides the approved and completed Concussion Release form to its member program (head coach, team manager, and registrar).

3. Should it be determined that above-named athlete needs to be removed from participation, I/we understand that the protocol outlined herein must and will be followed for the safety of the athlete.

4. I/we understand that if a suspected concussion has occurred and protocol has been enacted for the above-named athlete, there is no review period or negotiation as to the course of action and return to participation outside of the recommendations of the evaluating medical professional who has been selected to treat the athlete.

5. I/we understand that if I/we suspect the above-named athlete has experienced a concussion or exhibits behavior that suggests concussion-like symptoms, I/we have the authority to remove the athlete from participation and begin the concussion protocol with a medical professional of my/our selection who meets the criteria of an acceptable evaluator.

By the signature/s below, I/we acknowledge responsibility for the above-named athlete in the current season, and agree to all the information stated herein.

_____ _____
Name Date

_____ _____
Name Date