Trinity Washington University Sports Medicine

Student-Athlete Concussion Reporting Agreement

I _____ acknowledge that I have received and read the concussion fact sheet for student athletes. I understand that it is my responsibility to report any and all concussive events and concussion like symptoms to a member of the Trinity Washington University Sports Medicine Staff. The symptoms could include but are not limited to the following:

- Headache
- Neck pain
- Nausea
- Vomiting
- Lack of energy/physically mentally tired
- Dizziness
- Light-headedness
- Loss of Balance
- Blurred or double vision
- Sensitivity to light
- Sensitivity to sounds
- Ringing of the ears
- Loss of taste, touch or smell
- Irritability or change in sleep patterns

I understand that concussions and head injuries have the potential to be life threatening or can lead to Second Impact Syndrome. Concussions that are unreported and/or unmanaged carry a greater risk of traumatic brain injury. All head/neck related injuries MUST be reported to a member of the Trinity Washington University Sports Medicine Staff IMMEDIATELY upon occurrence.

_____ _____

Name of Student-Athlete (print clearly) **Sport**

_____ _____

Social Security Number of Student-Athlete **Date of Birth of Student-Athlete**

_____ _____

Signature of Student-Athlete **Date**

_____ _____

Name of Parent/Legal Guardian if student-athlete Is under the age of 18 years of age **Date**

_____

Signature of Parent/Legal Guardian if student-athlete is under the age of 18 years of age