Instruction Sheet for Student/Athlete Consent Forms A, B and Student & Parent Consent Form.

Student and parents/guardians must read, complete each form in its entirety, and sign all forms included in this packet in order to be eligible to participate in athletics at Wayne Community Schools.

Forms A, B and Student & Parent Consent Form must be completed and turned in to: Wendy Heikes, Athletic Director Office Assistant at the Junior/Senior High School prior to the first day of the sport you are participating in. Both parents must sign at the bottom of the Student & Parent Consent Form unless parents are divorced, then the custodial parent must sign. If student is not living with parents, the student's legal guardian must sign.

If you have any questions, please call Wendy or the Athletic Director, Mr. Wragge, at (402) 375-3150. If you have questions about immunizations, please call the school nurse at (402) 375-3854 or (402) 375-3150.

NOTE:

Please fill out forms A, B and Student & Parent Consent form and return to: Wendy Heikes, A.D. Office Assistant at the Junior/Senior High School. These forms must be completed and received before a student/athlete will be determined eligible for any type of participation.

Do not take these forms to a clinic. The clinic(s) do not want to be responsible for these forms.

Form A-Turn this form into the high school office.

2026-2027
WAYNE COMMUNITY SCHOOLS
EXTRACURRICULAR ACTIVITIES

EMERGENCY INFORMATION

Student's Name:	DOB:	Grade Level:

Emergency Contact Information

	Home #	Work #	Cell #
Primary Contact/Relationship:			
1st Secondary Contact/Relationship:			
2nd Secondary Contact/Relationship:			

Medical Provider Information

Student's Physician:	Telephone:	
Student's Dentist:	Telephone:	
Insurance Co.:	Name on insurance card:	Insurance ID#:

Medical Background (for Athletic Participants)

Date of Tdap:	Blood Type:
Allergies to Drugs:	Allergies to Foods:
Student's medications an emergency responder should be aware of	
Other information an emergency responder should be aware of::	

Any other pertinent information coaches or sponsors should know about related to emergency response for the student: _____

_____

Date:_____ X_____
(Signature of Parent/Guardian)

Over →

Permit to Attend Athletic Event/Medical Consent Form
2026-27

It is understood that the child is still under school supervision, but neither the school district nor those in charge shall be held responsible in case of an accident.

In the event an accident or injury does occur, permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examinations, and/or immunizations for the above named student.

The administration, staff, team trainer, or coach will apply first aid treatment until a doctor can be contacted. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact parents/guardians in the most expeditious way possible. If said physician is not able to communicate with parents/guardians, the treatment necessary for the best interest of the above named student may be given.

I/we acknowledge that parents/guardians are obligated to pay for professional medical and/or related services; the school shall not be liable for payment of such services.

I/we give our consent for administration, staff, coaches, trainers, and physicians to use their own judgment in securing medical aid and ambulance service in case, the parents/guardians, cannot be reached.

X_____ _____

Parent/Guardian Signature **Date**

****This form is valid through the 2026-2027 school year.**

Form B-Turn this form into the high school office.

2026-2027
WAYNE COMMUNITY SCHOOLS
STUDENT AND PARENT CONSENT FOR
INTERSCHOLASTIC PARTICIPATION

I _____ **(Student's Name)** request to participate in Wayne Community Schools interscholastic activities in the 2026-2027 school year. In making this request, Student states: This application to participate in interscholastic activities for the Wayne Community Schools is entirely voluntary on my part. I have read the eligibility rules and regulations of the Nebraska School Activities Association and the rules and regulations of Wayne Community Schools. I am not in violation of such rules.

(I am)(We are) the Student's parent or guardian ("Parent") and hereby give consent for the Student to participate in Wayne Community Schools interscholastic activities in the 2026-2027 school year.

Date:_____ X_____
(Signature of Parent/Guardian)

Date:_____ X_____
(Student Signature)

Parent and Student hereby give the following statements, agreements and consents:

WARNING OF RISK: I realize that participation involves the potential for injury which is inherent in all interscholastic activities. Even with the protective equipment, safety rules and instruction and direction of coaches and sponsors that are provided, injuries are still a possibility. The severity of such injury can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries to the body's bones, joints, ligaments, tendons, or muscles, to catastrophic injuries to the head, neck and spinal cord, and on rare occasions, injuries so severe as to result in total disability, paralysis, and death. *I acknowledge that I have read and understand this warning.*

MEDICAL: Parent is responsible for any professional medical and/or related services; the school shall not be liable for payment of such services. Parent and Student give permission to any and all of the Student's health care providers to release and discuss all records and information such health care providers may have about Student (including otherwise confidential medical information and records) to Wayne Community Schools and its employees, staff, agents, and consultants. Parent and Student further give permission to Wayne Community Schools, its employees, staff, agents, and consultants to release and discuss all records and information it has (including otherwise confidential medical information or records) to Student's health care providers and to others as Wayne Community Schools may determine appropriate for the purposes of determining activity eligibility, fitness, or injury status, or to respond to an emergency.

INSURANCE: I acknowledge that insurance coverage is recommended for all participants. The expense of insurance coverage is Parent's responsibility. Information regarding insurance is available in the Athletic Director's office.

INJURY REPORTING: Parent and Student agree to report to coaches and trainers any injury what-so-ever suffered by Student before, during, or after the season, practice, or games, whether such injury occurred as a part of participation in the extracurricular activity or outside of such activity.

Form B-Turn this form into the high school office.

ELIGIBILITY RULES: The major rules and regulations governing Student's eligibility to participate in interscholastic activities have been disclosed to Student and Parent. I have read the Nebraska School Activities Association rules of eligibility for participation in interscholastic activities, including the parent domicile, student transfer, and scholastic rules. I understand that activity participants must be enrolled in at least twenty hours per week, have regular in attendance and have on school records a minimum of 20 hours credit for the immediate preceding semester. Wayne Community Schools includes additional eligibility requirements as set forth in the Parent-Student Handbook.

TRANSPORTATION: I understand the activity may be conducted at a location other than Wayne Community Schools. In some instances Wayne Community Schools will not provide transportation to the activity. In such cases transportation to the site is the responsibility of Parent and Student. I understand that Wayne Community Schools is not responsible when Student is provided transportation by a private vehicle driven by others.

GOOD SPORTSMANSHIP: I understand good sportsmanship is essential to the success of the activity program. A failure to follow the principles of good sportsmanship or other inappropriate behavior may result in removal from the contest and may result in suspension from attending future contests or activities.

RELEASE OF INFORMATION: I consent to academic information including grade point average, class rank, and any academic awards/recognition received by Student to be released. Most typically this information will be used for the purpose of recognizing excellence in both athletics and academics and released for publication in newspapers, school publications, awards banquets or assemblies, and all-conference or all-state awards.

UNIFORM/EQUIPMENT RETURN:
I agree to return all uniforms and equipment issued to me promptly on request in good condition, subject to wear and tear that occurs from normal use. I accept financial responsibility for the return of items assigned to Student and agree to reimburse the school the actual replacement value of the items in the event that they are not returned or are damaged, or for cost of repairs if they can be repaired. I understand that failure to reimburse the school in a timely fashion could affect extracurricular activity eligibility.

ACTIVITY CODE: The Wayne Community Schools Parent-Student Handbook includes an Activity Code that sets out rules of behavior. Student agrees to comply with the Activity Code. In the event I am uncertain as to whether particular behavior or conduct would violate the Activity Code, I understand that I should ask the Athletic Director for advice before engaging in the behavior or conduct. I agree that participation in extracurricular activities is a privilege that may be denied by suspension or other discipline if Student does not comply with the Activity Code.

I agree that the Activity Code is a set of school rules and are not to be interpreted the same way as a criminal code. As such, I agree that the rules are subject to interpretation by school officials. I also agree that school officials may determine that a violation of the Activity Code has occurred when school officials reasonably determine from whatever information they find credible that the Student engaged in the conduct in question. School officials may determine that a violation of the Activity Code has occurred even though a criminal charge related to the conduct is still pending and even if Student has been found not guilty or the criminal charge has been otherwise dismissed.

NSAA Athletic and Activities
Student and Parent Consent Form

School Year:
Member High School:
Name of Student:
Date of Birth: Place of Birth:
Name of Parent(s), Guardian(s), or Person(s) in Charge:
Relationship to Student:
Address(es) of Student and Parent(s)/Guardian(s)/or Person(s) in Charge**:

Note: If Student and all Parents/Guardians do not live in the same household, please include all addresses and inform the Member School as this may impact eligibility.

The undersigned(s) are the Student and the parent(s), guardian(s), or person(s) in charge of the above-named Student and are collectively referred to as "Parent".

The Parent and Student hereby:

(1) Understand and agree that participation in NSAA sponsored activities is voluntary on the part of the Student and is a privilege and understand and agree that (a) by this Consent Form the NSAA has provided notice of the existence of potential dangers associated with athletic and activity participation; (b) participation in any activity may involve injury or illness of some type, including exposure to communicable diseases, and even catastrophic injury, paralyzation, and death; and (c) even the best supervision, the use of the best protective equipment and strict observance of rules, injuries are still a possibility;

(2) Consent and agree to participation of the Student in NSAA activities subject to (a) all NSAA Bylaws and rules interpretations, including limitations on transfers and limitations on the use of the Student's name, image, and likeness when wearing school uniforms or engaging in commercial activity tied to the Student's participation in NSAA activities; and (b) the athletic and activities rules of the Member School;

(3) Consent and agree to the disclosure by the Member School to the NSAA, and subsequent disclosure by the NSAA, of information regarding the Student contained in the Member School's directory information or other similar policies, and any other records or documentation needed to determine the Student's eligibility and compliance necessary to participate in NSAA activities;

(4) Understand that (a) prior to athletic participation, a pre-participation release form signed by a health care professional must be signed and submitted to the Member School; and (b) for purposes of determining fitness to participate, injury, injury status, or emergency response, Parents may be asked to consent to the disclosure of confidential medical records or information. Records and information shared for this purpose will not be redisclosed to any entities outside of the health care provider(s), Member School, or NSAA;

(5) Consent and agree (a) to authorize licensed or trained individuals, including certified sports injury personnel, to evaluate and treat any injury or illness that occurs during the Student's participation in NSAA activities. This includes all reasonable and necessary care, treatment, and rehabilitation for these injuries that is made available by the Member school and/or the NSAA, including transportation of the Student to a medical facility if necessary; and (b) that Parents are obligated to pay for professional medical and/or related services; the NSAA and the Member School shall not be liable for payment of such services even if made available by the Member School or NSAA.

(6) Understand that the Student or Student's likeness being photographed, video recorded, audio taped, or recorded by any other means while participating in NSAA activities and contests and that any such recording may be used for broadcast, sale, or display.

We, Parent(s) and Student, acknowledge that I have read paragraphs (1) through (6) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletics and activities, and agree that Student may participate in NSAA activities.

Student Printed Name	**Student Signature**	**Date of Signature**
Parent(s) Printed Name(s)	**Parent Signature(s)**	**Date of Signature(s)**

Revised October 2022

Instruction Sheet for Student/Athlete Physical Forms (History, Physical Exam & Medical Eligibility

Student and parents/guardians must read, complete each form in its entirety, and sign all forms included in this packet in order to be eligible to participate in athletics at Wayne Community Schools.

The History form must be completed and taken to the Doctor's office. The Physical Exam and Medical Eligibility forms will be filled out by the Doctor. *You MUST bring all forms to Wendy Heikes in the Junior/Senior High School office.

**Please sign the bottom of the Physical Exam form so information can be released to the school. The History Form should be filled out prior to the Exam.

ACCORDING TO STATE STATUTE, ALL ATHLETES ARE REQUIRED TO COMPLETE A PHYSICAL EXAMINATION.

NOTE: Complete & sign the History form before seeing your doctor. *Be sure to sign the bottom of the Physical Exam form.
The History, Physical Exam, and Medical eligibility forms must be completed before a student/athlete will be determined eligible for any type of participation.

Athletes will not be permitted to practice or compete in any Nebraska School Activities Association sponsored activities until the athlete has been examined and is determined to be physically fit for athletic participation. The physical must be taken once each year. **A physical given May 1 or after will be acceptable for the following school year.**

Please call the Clinic of your choice to inquire if they are offering a **special physical price for grades 7-12 starting May 1st**. If you have insurance, you may want to call and see if it covers a physical. Let the clinic know when you schedule the appointment if you are interested in a special or if you want them to file the visit to your insurance.

You must bring all forms to Wendy Heikes at the Junior/Senior High School office.

If you have any questions, please call Athletic Assistant, Wendy Heikes or Athletic Director, Mr. Wragge, at (402) 375-3150. If you have questions about immunizations, please call the school nurse (402) 375-3854 or (402) 375-3150.

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM E

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart* • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

* Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a comination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

I hereby give permission for the release of the attached student medical history and the results of the actual physical examination to the school for the purposes of participation in athletic activities.

Parent or Legal Guardian's Signature _____ *Date* _____

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM F

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

Wayne Community Schools

2026-27 Concussion Policy

See WCS District Policy 6283

In compliance with the Nebraska Concussion Awareness Law LB 260 (7-1-2012) and LB 923 Return to Learn Amendment (4-22-2014), Wayne Community Schools has entered into official policy the directives and responsibilities as identified in such laws.

The Nebraska Concussion Awareness Law LB260 was enacted to provide a means for schools to improve their athletic health care; improve their methods for managing sports-related concussions and the progression for concussed athletes return to play in a more consistent, objective, and safe manner; educate schools, coaches, athletes, and parents to recognize the signs, symptoms, and inherent risk of sports-related concussions.

LB 923 The Return to Learn Amendment is a revision of LB 260 and established a return to learn protocol for students that have sustained a concussion. The return to learn protocol shall recognize that students who have sustained a concussion and returned to school may need informal or formal accommodations, modification of curriculum, and monitoring by medical or academic staff until the student is fully recovered.

In compliance with LB 260 & LB 923, the following step by step policy will be followed when an athlete is ***"reasonably suspected"*** of having received a concussion or anytime an athlete is removed from a game, practice or sports activity due to a suspected concussion prior to "return to play", sports' participation or any school sponsored physical activity.

Step 1: *The athlete will immediately be removed from play, sports participation and all physical activity. No athlete suspected of having sustained a concussion will return to athletic activity until the succeeding steps are fully completed.*

"When in doubt, sit them out!" The concussed brain is most vulnerable to a repeat injury (2nd Impact Syndrome) following the initial concussion. The 2nd injury is very critical to guard against. Previously, athletes were allowed to return to play during the same day, game or practice in which the injury occurred if their symptoms resolved during the course of that activity. Studies have now shown us that the young brain does not recover quickly enough for an athlete to return to activity in the same day of injury. Once a concussion occurs, the brain is most vulnerable to further injury and very sensitive to any increased stress until it fully recovers. If an athlete returns to activity before being fully healed from a concussion, the athlete is at increased risk for a repeat concussion. A repeat concussion that occurs before the brain has a chance to recover from the first can slow recovery or increase the chance for long-term potentially life threatening complications.

Step 2: *The athlete's parents or guardians will be contacted about the suspected concussion.*

Parents or Guardians will be notified immediately after the injury and will be provided information on Wayne Community School's Concussion Policy and will review the subsequent concussion management protocol.

Step 3: *All athletes suspected of having a concussion must be medically evaluated by a licensed health care professional trained in the evaluation and management of traumatic brain injury among a pediatric population before they are eligible to return to play.*

If the injured athlete is formally medically diagnosed with having sustained a concussion, Steps 4 thru 6 will be followed accordingly and the injured athlete will be disqualified to return to play until all steps are satisfactorily completed.
If the injured athlete is formally and medically determined to "NOT" have sustained a concussion, the injured athlete may then return to play upon having provided a satisfactorily completed Return to Play (RTP) form which requires clearance and signatures from both the examining medical provider and parent/guardian.

Step 4: *The Wayne Community Schools Concussion Management Team (CMT) will be notified of the injured athlete.*

A successful Return to Learn is necessary before Return to Play may be activated. In compliance with Nebraska LB 923, the Wayne Community Schools CMT will design an individual plan to review the student's concussion recovery and make the necessary academic accommodations until that student no longer needs them as a result of the concussion. After the CMT certifies that no further academic concerns or accommodations are needed, the student may be released to begin the progressive return to play program.

Step 5: *ImPACT Test - Immediate Post-Concussion Assessment and Cognitive Testing.*

ImPACT is an on-line computer-based testing program specifically designed for the management of sports-related concussion. It is a research-based software tool developed at the University of Pittsburg Medical Center that evaluates multiple aspects of neurocognitive function.

ImPACT is the industry leader in neurocognitive post-concussion testing. Current ImPACT clients include the NFL, NBA, NHL, MLB, numerous NCAA Division I Football programs and multiple high schools throughout the United States & Nebraska.

Testing involves a pre-activity baseline test and post-injury test for comparison. When a concussion has occurred, the post-injury test is compared to the baseline report to assess potential changes caused by a concussion. The injured athlete must present satisfactory computer-evaluated post-concussion test scores that indicate neurocognitive function has returned to pre-injury baseline testing levels

ImPACT measures multiple aspects of neurocognitive functioning in athletes, including

- Player symptoms
- Verbal and visual memory, processing speed, and reaction time
- Reaction time measured to a 1/100th of second
- Attention span
- Working memory
- Sustained and selective attention time
- Response variability
- Non-verbal problem solving

Step 6: *Written clearance/consent to return to play by a licensed health care professional, trained in the medical evaluation and management of traumatic brain injury among a pediatric population.*

Before initiating Step 7 Progressive Return to Play, the injured athlete must;

1. Have provided written clearance/consent from the examining medical provider;
2. Have provided written clearance/consent from parents/guardians;

3. Has been certified by the school's Concussion Management Team to Return to Learn;

4. Has satisfactorily completed the ImPACT Post-Concussion Test;

5. Is symptom-free at rest, remains symptom-free or no longer presents signs or symptoms of a concussion in an effort to allow the brain to continue to heal and to re-adjust to physical exertion, the injured athlete may proceed with activity in a gradual step-wise Progressive Return to Play (RTP) Program.

Step 7: *Progressive Return to Play (RTP) Program.*

24 hours will be required between each step before advancing to the next step as monitored and directed by the Wayne HS Athletic Trainer. The concussed athlete must remain symptom-free before proceeding to the next step. The concussed athlete will be re-evaluated daily prior to the start of each new step.

This process will be repeated until the athlete can complete all steps and remain symptom free. The injured athlete will NOT be allowed to begin the gradual progression for return to sport activity until the program has been satisfactorily completed.

If concussion symptoms, signs or behaviors recur or are observed, the athlete must stop all activity and be re-evaluated by a licensed health care professional. The athlete may not resume the Progressive Return to Play Program until being symptom free. Once the concussed athlete is symptom free, they may resume the Progressive Return to Play Program starting over with Step 1.

The return to play schedule will proceed as follows:

Step 1: Symptom-free at rest. No physical or mentally taxing activity.

Step 2: Light aerobic exercise. Low level activity. No weight lifting or resistance training.

Step 3: Moderate aerobic exercise. Running at moderate intensity without equipment.

Step 4: Sport specific drills. Non-contact drills. May begin weight lifting or resistance training.

Step 5: Full contact practice, scrimmage or training drills.

Step 6: Full game or competition play.

All injuries and/or illnesses preventing an athlete from sports participation must be reported to the Wayne HS Sport Head Coach and/or Wayne HS Athletic Trainer. Athletic injury return to play progression is monitored by the Wayne HS Athletic Trainer under the direction of and approval by the examining medical provider.

All athletes requiring medical evaluation for injuries or illnesses that subsequently prevent the athlete from sport participation (whether or not the result of athletic participation), are required to provide a satisfactorily completed "Return to Play" clearance form signed by parent(s) or guardian(s) and the examining medical provider.

I, _____parent/guardian of

_____ have read the information concerning concussions and Nebraska Concussion Awareness Law LB260 and the Return to Learn Amendment Law LB923.

_____

Signature of Parent or Guardian

Wayne Community School Health History Form

Return by August 22nd or fax to Elementary (402)-375-1702 or High School 402)-375-5251

Student Name:_____ Grade: _____ Sex: M/F _____

Birth Date: _____ Health Care Provider: _____ Dentist: _____

The following information is requested to assist the school staff in responding appropriately to your student's health needs. The information provided here may be shared with school personnel as needed to promote your child's safety and educational success at school.

A. Current Health Status

1. Does your child take medicine or supplements regularly? ☐No ☐Yes
   Please list: _____
2. Does your child have a health condition now under treatment? ☐No ☐Yes
   Please list: _____
3. Has your child been hospitalized in the last 3 years, treated in ER, or had surgery? ☐No ☐Yes
   Please list: _____
4. Does your child have allergies to food? ☐No ☐Yes
   Please list type and reaction: _____
5. Does your child have allergies to medications? ☐No ☐Yes
   Please list type and reaction: _____
6. Does your child have environmental, seasonal, bee/insect, or pet allergies? ☐No ☐Yes
   Please list type and reaction: _____
7. Date of last: Medical exam _____ Dental exam _____ Eye exam _____
8. In the past year has your child had any immunizations? Type_____Date_____Clinic_____

☐**YES**, my child receives medical care for following conditions below: ***or*** ☐**NO** medical conditions below

Asthma ☐No ☐Yes _____Inhaler/nebulizer Y/N_____ Diabetes ☐No ☐Yes _____

Heart Condition ☐No ☐Yes _____ Epilepsy/Seizures ☐No ☐Yes _____

Bleeding Disorder ☐No ☐Yes _____ Chronic Respiratory Problems ☐No ☐Yes _____

Chronic Ear Infections ☐No ☐Yes _____ Head Injuries/Concussions/Migraines ☐No ☐Yes _____

Bowel/Bladder Problems ☐No ☐Yes _____ Digestive Disorders ☐No ☐Yes _____

Kidney Disease ☐No ☐Yes _____ Mental/Emotional/Behavior Concerns/Depression ☐No ☐Yes_____

Vision/Hearing/Mobility Concern ☐No ☐Yes _____ Glasses/contacts : ☐No ☐Yes

ADD/ADHD ☐No ☐Yes Skin conditions ☐No ☐Yes Autism ☐No ☐Yes Bone/muscle/joint problems ☐No ☐Yes

Congenital/Birth Malformations ☐No ☐Yes_____ Speech problems ☐No ☐Yes Hearing problems ☐No ☐Yes

Is there anything more about your child's health that you think is important for us to know?

_____

_____

Parent Signature _____ Date _____

Formulario de Historial de Salud de las Escuelas Comunitarias de Wayne
Devuélvalo antes del 22 de agosto o envíe un fax a Wayne Community Schools (402)-375-5251

Nombre del estudiante:_____ Grado: _____ Sexo: M/F _____

Fecha de nacimiento: _____ Proveedor de atención médica: _____ Dentista: _____

La siguiente información es solicitada para ayudar al personal de la escuela a responder adecuadamente a las necesidades de salud de su estudiante. La información proporcionada aquí se puede compartir con el personal de la escuela según sea necesario para promover la seguridad y el éxito educativo de su hijo en la escuela.

A. Estado de salud actual

1. ¿Su hijo toma medicamentos o suplementos regularmente? ☐No ☐Sí
   Por favor enumere: _____
2. ¿Su hijo tiene una condición de salud ahora bajo tratamiento? ☐No ☐Sí
   Por favor enumere:_____
3. ¿Su hijo ha sido hospitalizado en los últimos 3 años, ha sido tratado en la sala de emergencias o ha tenido una cirugía? ☐No ☐Sí
   Por favor enumere: _____
4. ¿Su hijo tiene alergias a los alimentos? ☐No ☐Sí
   Por favor enumere el tipo y la reacción: _____
5. ¿Su hijo tiene alergias a medicamentos? ☐No ☐Sí
   Por favor enumere el tipo y la reacción: _____
6. ¿Su hijo tiene alergias ambientales, estacionales, a las abejas/insectos o a las mascotas? ☐No ☐Sí
   Por favor enumere el tipo y la reacción: _____
7. Fecha del último: Examen médico _____ Examen dental _____ Examen de la vista _____
8. En el último año, ¿su hijo recibió alguna vacuna? Tipo_____Fecha_____Clínica_____

☐**SÍ,** mi hijo recibe atención médica para las siguientes condiciones a continuación: **o** ☐**NO** condiciones médicas a continuación

Asma ☐No ☐Sí _____Inhalador/nebulizador S/N_____

Condición cardíaca ☐No ☐Sí _____

Trastorno hemorrágico ☐No ☐Sí _____

Infecciones crónicas del oído ☐No ☐Sí _____

Problemas de vejiga/intestinales ☐No ☐Sí _____

Enfermedad renal ☐No ☐Sí _____

Problemas de visión/audición/movilidad ☐No ☐Sí _____

Diabetes ☐No ☐Sí _____

Epilepsia/Convulsiones ☐No ☐Sí _____

Autismo ☐No ☐Sí

Malformaciones congénitas/de nacimiento ☐No ☐Sí_____

Problemas respiratorios crónicos ☐No ☐Sí _____

Lesiones en la cabeza/conmociones cerebrales/migrañas ☐No ☐Sí _____

Trastornos digestivos ☐No ☐Sí _____

Preocupaciones mentales/emocionales/de comportamiento/depresión ☐No ☐Sí _____

Anteojos/Contactos: ☐No ☐Sí

ADD/ADHD ☐No ☐Sí

Condiciones de la piel ☐No ☐Sí

Problemas de huesos/músculos/articulares ☐No ☐Sí

Problemas del habla ☐No ☐Sí Problemas de audición ☐No ☐Sí

¿Hay algo más sobre la salud de su hijo que cree que es importante que sepamos?

_____

_____

Firma del padre _____ Fecha _____