



**California Amateur Hockey Association
Concussion Awareness and Protocol
Parent/Guardian Acknowledgement Form
Youth Hockey**

Player Name: _____ Season: _____

Level of Play: _____ Program: _____

1. I understand that the California Amateur Hockey Association has adopted concussion-related education, awareness and protocol into their Guidebook and Rules of Play.
2. I understand the following guidelines and protocol exist, and will respect them if they must be instituted with the above-named player:
 - a. An athlete who is suspected of sustaining a concussion or head injury in an athletic activity shall be immediately removed from the activity for the remainder of the day. Removal from play can be at the request of a coach, official, team manager, parent/guardian, or the player.
 - b. Athlete shall not be permitted to return to the activity until he/she is evaluated by a medical professional trained in the management of concussions. Acceptable evaluators must be medical professionals with one of the following medical license designations: MD, DO, Neurologist, Neuropsychologist.
 - c. Further, the athlete shall not be permitted to return to activity until he or she provides the approved and completed Concussion Release form to the Club, from the evaluating medical professional.
3. Should it be determined that a player needs to be removed from play, I/we understand that the protocol outlined herein must and will be followed for the safety of the player. Further, I/we understand that the above named player will receive concussion education during the course of the season.
4. I understand that if a suspected concussion has occurred and protocol has been enacted for the above named player, there is no review period or negotiation as to the course of action and return to play outside of the recommendations of the evaluating medical professional who has been selected to treat the player.
5. I/we understand that if I/we suspect the above named player has experienced a concussion or exhibits behavior that suggests concussion-like symptoms, I/we have the authority to remove the player from play 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 player in the current season, and agree to all of the information stated herein.

Name

Date

Name

Date