

Concussion Notification Form

Athlete name _____ Date of injury _____

Parent/Guardian _____

Area _____ District _____

Coach name _____ Phone number _____

Injury occurred during: *(please circle one)*

Practice Game Scrimmage Tournament Other

How did the injury occur?

During soccer activities your child/athlete may have received a concussion. It is very important both you and your athlete understand the implications of a concussion and be aware of the steps that need to be followed before the athlete can return to the field of play for practice or games.

When experiencing a concussion it is common to have one or many symptoms. Please refer to SAY concussion parent information sheet which was given to you by your Area/District for a list of symptoms. Concussion symptoms can occur right away or up to 48 hours after injury.

Please be advised that an athlete who is removed from play due to a suspected concussion may not return to the field of play the same day under any circumstances. The child/athlete may not return to practice or any soccer activity until a doctor has provided a written release permitting return to play. The signed medical release must be presented to the coach and SAY league officials prior to re-entering team activities.

Coach signature _____ Date _____

Parent signature _____ Date _____

Athlete signature _____ Date _____

Referee signature _____ Date _____

Return to Play Form

This form is to be used after an athlete is removed from the field of play after exhibiting concussion symptoms.

SAY Soccer rules require written authorization from a physician or other licensed medical professional before an athlete may return to play after exhibiting concussion symptoms that cause that athlete to be removed from the field. This athlete MAY NOT return to play nor participate in any SAY activity on the same day that he or she has been removed (even if a written medical clearance is provided).

Athlete name _____ **Date of injury** _____

Parent/Guardian _____

Area _____ **District** _____

Injury occurred during: *(please circle one)*

Practice Game Scrimmage Tournament Other

REASON FOR ATHLETE'S INCAPACITY

PHYSICIAN'S ACTION

I have examined the named athlete following the episode and determined the following:

Permission is granted for the athlete to return to competition (may **not** return to practice or competition on the same day as the injury).

COMMENTS: _____

Physician's Signature _____ **Date** _____

Physician's Printed Name _____

Physician's Primary Location of Practice _____

Physician's Primary Office Phone # _____

Copies to: Team Coach, Area and/or District President *(Duplicate as Needed)*