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 __________