Possible Concussion Notification
For OYSAN Soccer Events

Today, _______________________, 2, at the ______________________ [insert name of event], ______________________ [insert player’s name] received a possible concussion during practice or competition. US Youth Soccer and Staff want to make you aware of this possibility and signs and symptoms that may arise which may require further evaluation and/or treatment.

It is common for a concussed child or young adult to have one or many concussion symptoms. There are four types of symptoms: physical, cognitive, emotional, and sleep.

If your daughter or son starts to show signs of these symptoms, or there any other symptoms you notice about the behavior or conduct of your son or daughter, you should seek immediate medical attention:

- Memory difficulties
- Headaches that worsen
- Vomiting
- Focus issues
- Seizures
- Weakness/numbness in arms/legs
- Neck pain
- Odd behavior
- Fatigued
- Irregular sleep
- Delicate to light or noise
- Repeats the same answer or question
- Slurred speech
- Irritability
- Fatigued
- Slow reactions
- Seizure Patterns
- Less responsive than usual

Please take the necessary precautions and seek a physician or licensed healthcare provider before allowing your daughter or son to participate further. Until a medical professional is seen, please consider the following guidelines:

- refraining from participation in any activities the day of, and the day after, the occurrence.
- refraining from taking any medicine unless (1) current medicine, prescribed or authorized, is permitted to be continued to be taken, and (2) any other medicine is prescribed by a licensed health care professional.
- refraining from cognitive activities requiring concentration cognitive activities such as TV, video games, computer work, and text messaging if they are causing symptoms.
Please be advised that a player who has been suspected of a concussion may not return to play until they are provided a written clearance that it is safe for the individual to return to practice or competition from a licensed physician or a licensed healthcare provider. A non-licensed healthcare provider would have to work:

(a) In consultation with the physician
(b) pursuant to the referral of a physician
(c) in collaboration with a physician
(d) under the supervision of a physician.

Player’s Team: _______________________________________

Age Group: _______________________________________

Player Name: ______________________________________ Gender: _________

Player Signature: ___________________________________ Date: ____________

Parent/Legal Guardian Signature: _______________________ Date: ____________

Team Official Signature: ______________________________ Date: ____________

**Parent/Legal Guardian:** By inserting my name and date, I confirm that I have been provided with, and acknowledge that, I have read the information contained in the Form.

**Coaches/Officials:** Retain this signed copy for your records. If the parent/legal guardian requests a copy, please fill out in duplicate or photocopy the original for them.

References:


Return-to-Play Verification

Verification that it is safe for ________________ to return to practice or competition.

On the ______ day of ________________ , 20___ , the undersigned licensed physician or licensed healthcare provider acting in accordance with O.R.C. § 3707.511(E)(b)(2) may safely return to practice and/or competition for the concussion or possible concussion that occurred on the _____ day of ________________ , 20__.

______________________________
Physician/Licensed Healthcare Provider