Notification of Possible Concussion
For Georgia Soccer Events

(Affiliate will complete this form in duplicate, keeping one signed copy)

Today, _____ [month & day], 2_____ [year], during practice / game [circle which] held at

_____ [insert field/venue],

_____ [insert player's name] received a possible concussion.

We want to formally advise you of this possibility, and also remind you of the signs and symptoms that may arise from such an injury which shall require further evaluation and/or treatment by a Georgia licensed medical professional.

Having been so notified of this possible head injury, your child <u>will not</u> be allowed to participate in any further Georgia Soccer sanctioned games or practices until your child is evaluated by an authorized Health Care Provider who subsequently provides us with a written approval for your child to safely return to play. This authorization form is found below. This decision is made in the best interest of your child's safety and well-being.

It is common for a concussed player 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 consider seeking immediate medical attention. These symptoms might include, among other signs, the following:

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

Please take the necessary precautions and seriously consider seeking a professional medical opinion should your child exhibit any of the above symptoms. Georgia Soccer requires that your medical professional also clears your child for return to soccer activity before you allow your daughter or son to participate further. Until you, as parent or legal guardian, get authorization for your child to return to play after seeking a professional medical opinion, please consider the following guidelines for your child:

- Refrain from participation in any activities the day of, and the day after, the occurrence.
- Refrain 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.
- Refrain from cognitive activities requiring concentration such as TV, video games, computer work, and text messaging if they are causing symptoms.

If you are unclear and have questions about the above symptoms, please immediately contact a medical doctor for evaluation and/or clarification on your child's condition.

Revised 8.31.2016

Your child **will not** be permitted to return to play in any Georgia Soccer affiliated activity until you sign and return the "**RETURN TO PLAY" AUTHORIZATION** form.

_____ _____

(Signature of Affiliate Coach/Representative) (Signature of Parent or Legal Guardian)

GEORGIA SOCCER "RETURN TO PLAY" AUTHORIZATION

(To be signed by the Player's Parent or Legal Guardian and Returned to the Affiliate)

By inserting my name and date below, and returning this "Return to Play" Form to my local Georgia Soccer Affiliate, I acknowledge that I have read the information contained in the original notification form. I also acknowledge that I am the player's parent or legal guardian and that I have been advised by Georgia Soccer of common Concussion symptoms, including the requirement in getting professional medical clearance before authorizing my child's return to play soccer within any Georgia Soccer sanctioned activity.

Please be advised that a player formally identified as suffering a possible concussion injury shall not return to play until the player's parent or legal guardian confirms that they have a professional medical opinion of their child's fitness to resume playing before returning this signed authorization to the local soccer affiliate.

Player Name [Print]: _____

Player's Team [Print]: _____

Player's Affiliate/Club Name [Print]: _____

Age Group & Competitive Division [Print]: _____

Parent/Legal Guardian Name [Print]: _____

Parent/Legal Guardian Signature: _____Date: _____

Team Official Name [Print]: _____

Team Official Signature: _____Date: _____

Revised 8.31.2016

STATEMENT OF RELEASE TO RETURN TO PLAY BY GA. LICENCED HEALTH CARE PROVIDER

I have examined the above named player and my professional medical opinion is that he/she is able to return to play [circle one] immediately/graduated participation*

[state period of time] _____

*Attach any supporting documents/prescription.

Ga. Licensed Health Care Provider Name [Print] _____

Ga. Licensed Health Care Provider Signature: _____ Date: _____

Ga. License Number (if applicable) _____ Expiration Date: _____

Contact Address: _____

Contact Phone: Cell: _____ Office: _____

[THE LOCAL GEORGIA SOCCER AFFILIATE IS REQUIRED TO MAINTAIN A COPY OF THIS RECORD FOR FUTURE REFERENCE]