Coach/School Nurse/Volunteer Concussion Statement

☐ I have read the *Concussion Information Sheet.* *If true, please check box.*

☐ I should not allow any student-athlete exhibiting signs and symptoms consistent with concussion to return to play or practice on the same day. *If you agree, please check box.*

After reading the information sheet, I am aware of the following information:

_____ A concussion is a brain injury.
Initial

_____ A concussion can affect a student-athlete's ability to perform everyday activities, their ability to think, their balance, and their classroom performance.
Initial

_____ I realize I cannot see a concussion, but I might notice some of the signs in a student-athlete right away. other signs/symptoms can show-up hours or days after the injury.
Initial

_____ If I suspect a student-athlete has a concussion, I am responsible for removing them from activity and referring them to a medical professional trained in concussion management.
Initial

_____ Student-athletes need written clearance from a medical professional trained in concussion management to return to play or practice after a concussion.
Initial

_____ I will not allow any student-athlete to return to play or practice if I suspect that he/she has received a blow to the head or body that resulted in signs or symptoms consistent with concussion.
Initial

_____ Following concussion the brain needs time to heal. I understand that student-athletes are much more likely to sustain another concussion or more serious brain injury if they return to play or practice before symptoms resolve.
Initial

_____ In rare cases, repeat concussions can cause serious and long-lasting problems.
Initial

_____ I have read the signs/symptoms listed on the Concussion Information Sheet.
Initial

_____ _____
Signature of Coach/School Nurse/Volunteer Date

_____
Printed name of Coach/School Nurse/Volunteer