Possible Concussion Notification

Today, _____, 2____, at the _____, _____ received a possible concussion during practice or competition. US Youth Soccer and Staff want to make you aware of this possibility and symptoms that may arise which may require further evaluation and/or treatment.

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:

- Memory difficulties
- Headaches
- Vomiting
- Focus issues
- Neck pain
- Odd behavior
- Fatigued
- Irregular sleep Patterns
- Delicate to light or noise
- Repeats the same answer or question
- Slow reactions

Please take the necessary precautions and consider seeking a professional medical opinion before allowing your daughter or son to participate further. Until a professional medical opinion is provided, 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.

If you are unclear and have questions about the above symptoms, please contact a licensed health care professional. Please be advised that a player who suffers a concussion may not return to play until there is provided a signed clearance from a licensed medical doctor who specializes in concussion treatment and management.

Player Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

Team Official Signature: _____ Date: _____

By inserting my name and date as parent/legal guardian and returning this Form electronically, I confirm that I have been provided with, and acknowledge that, I have read the information contained in the Form. If returning the signed Form by mail, send it to the following address:
_____.