

Coach/School Nurse/Parent/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
Initial activities, their ability to think, their balance, and their classroom performance.
performance.

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

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

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

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

_____ Following concussion the brain needs time to heal. I understand that
Initial 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.

_____ 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

HMS Staff

Signature of Coach/School Nurse/Volunteer

X

Student-Athlete Name (for parents to
complete)

X
Printed name of Coach/Parent/School Nurse/Volunteer

Student-Athlete Concussion Statement

**If there is anything on this sheet that you do not understand, please ask an adult to explain or read it to you.*

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

☐ It is my responsibility to tell my parents, my coach, and/or a medical professional about my injuries and illnesses. If you agree, please check box.

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

Initial A concussion is a brain injury, which I am responsible for reporting to my coach(es), my parents, or a medical professional if one is available.

Initial A concussion can affect my ability to perform everyday activities, my ability to think, my balance, and my classroom performance.

Initial I realize I cannot see a concussion, but I might have some of the symptoms right away. Other symptoms can show up hours or days after the injury.

Initial If I think a teammate has a concussion, I am responsible for telling my coach(es), my parents, or a medical professional about their concussion.

Initial I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.

Initial I need written permission from a medical professional trained in concussion management to return to play or practice after a concussion.

Initial After a concussion, the brain needs time to heal. I understand that I am much more likely to have another concussion or more serious brain injury if I return to play or practice before my symptoms go away.

Initial Sometimes, repeat concussions can cause serious and long-lasting problems.

Initial I have read the concussion symptoms on the Concussion Information Sheet.

X

Signature of Student-Athlete

X

Date

X

Printed name of Student-Athlete