Possible Concussion or Head Injury Notification

Tournament/Event _____

In accordance with Florida Statute 943.0438, this is to notify you that today, _____, 20___, a player received a possible concussion or head injury during practice or competition. Under Florida law, this player must be removed from play or practice. Before the player may return to practice or competition a written medical clearance to return stating that the youth athlete no longer exhibits signs, symptoms, or behaviors consistent with a concussion or other head injury must be received from an appropriate health care professional trained in the diagnosis, evaluation, and management of concussions. In Florida, an appropriate health-care professional (AHCP) is defined as either a licensed physician (MD, as per Chapter 458, Florida Statutes), a licensed osteopathic physician (DO, as per Chapter 459, Florida Statutes), a licensed physicians assistant under the supervision of a MD/DO (as per Chapters 458.347 and 459.022, Florida Statutes) or health care professional trained in the management on concussions.

Symptoms that were observed are checked below:

_____ Dazed look or confusion about what happened

_____ Memory difficulties

_____ Neck pain, headaches, nausea, vomiting, double vision, blurriness, ringing noise or sensitivity to sounds

_____ Short attention span- Can't keep focused

_____ Slow reaction time, slurred speech, bodily movements are lagging, fatigue and slowly answers questions or have difficulty answering questions

_____ Abnormal physical and/or mental behavior

_____ Coordination skills are behind; ex: balancing, dizziness, clumsiness, reaction time

_____ Other: _____
_____

Please take the necessary precautions and seek an appropriate medical professional. Until a professional medical opinion in provided, please consider the following guidelines:

- 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

Player Signature _____ Date: _____

Parent/ Legal Guardian Signature _____ Date: _____

Team Official Signature _____ Date: _____

The above signed authorizes Florida Youth Soccer Association (FYSA) to release the information contained on this form upon request by email, mail or in person to the players authorized medical provider.

Rev 8/13