

**Notice to Parent(s)/Guardian of Suspected Concussion or Brain Injury and
Removal from Athletic Activities**

In accord with the Nebraska Concussion Awareness Act for any student athlete who has been removed from any practice or game when reasonably suspected of having sustained a concussion or brain injury.

Student Athlete's Name: _____

Sport/Athletic Activity: _____

Date of Injury/Incident: _____

Approximate Time of Injury/Incident: _____

Parent(s)/Guardian Name: _____

Parent(s)/Guardian Contact Information (e.g., address, phone, fax, e-mail, text):

1. Your son/daughter is suspected of having sustained a concussion or brain injury based upon the following signs and symptoms:

SIGNS – observed by a Coach/LHCP¹

- _____ Loss of Consciousness
- _____ Seizure Activity
- _____ Dazed or stunned appearance
- _____ Disorientation, confusion
- _____ Vacant stare, glassy-eyed
- _____ Slurred speech
- _____ Vomiting
- _____ Slow to answer questions
- _____ Repeatedly asking same question
- _____ Inability to recall events prior to injury
- _____ Inability to recall events after injury
- _____ Clumsy movements, balance problems
- _____ Behavior, mood or personality changes
- _____ Emotional instability (abnormal laughing, crying)
- _____ Unusual irritability
- _____ Other _____

SYMPTOMS – reported by athlete

- _____ Headache or “pressure” in head
- _____ Nausea, vomiting
- _____ Dizziness, balance problems
- _____ Double or blurred vision
- _____ Feeling sluggish/hazy/foggy/groggy
- _____ Weakness or numbness
- _____ Fatigue
- _____ Drowsiness
- _____ Difficulty concentrating
- _____ Difficulty remembering
- _____ Nervousness, anxiety
- _____ Sadness
- _____ Other _____

2. In addition to removing your son/daughter from athletic activity involving exertion, the following actions were taken by coaches or supervisory personnel:

_____ Checked for a neck or spinal injury

_____ Checked if immediate emergency care was needed

_____ Assessed orientation, memory, concentration and balance

_____ Continued observation and monitoring by coaches

_____ Other: _____

3. Your son/daughter will not be permitted to return to participation in any school-supervised athletic activities involving physical exertion, including, but not limited to, practices or games, (unless and) until he/she: (1) has been evaluated by a licensed health care professional²; (2) has received from the licensed health care professional written and signed clearance to resume participation in athletic activities involving physical exertion; (3) has submitted the written and signed medical clearance to an official of the organization that organized the athletic activity; and (4) has submitted with the medical clearance, written permission to resume participation from the youth athlete's parent(s) or guardian. (Sample forms may be available from the school.) (Nebraska Concussion Awareness Act; 71-9101 to 71-9106, R.S. Supp., 2011.)

Notification provided to: _____ Date: _____ Time: _____
Parent/Guardian

Notification provided by: _____ Phone: _____

¹Section 71-9103 of the Nebraska Statutes defines "Licensed Health Care Professional" for purposes of the **Concussion Awareness Act** as follows: "A physician, licensed health-care practitioner under the direct supervision of a physician, a certified athletic trainer, neuropsychologist, or some other qualified individual who (a) is registered, licensed, certified or otherwise recognized by the State of Nebraska to provide healthcare services and (b) is trained in the evaluation and management of traumatic brain injuries among a pediatric population."

² Id.