Verification of Incident-Notification by a School

As the parent or legal guardian of _____,
Name of Student

I hereby acknowledge and attest that I received notification from the school for which my son/daughter participates as a student athlete, that on _____, at
Date Cited for Incident

Approximately _____ a.m./p.m., he/she experienced an incident or injury that, after observation by a coach or licensed health care professional[1], resulted in reasonable suspicion that my son/daughter had sustained a concussion or brain injury and on that basis he/she was removed from athletic activity. I also acknowledge and attest that, in addition to the date and time, the notification I received also identified the signs and symptoms of a concussion or brain injury that were observed and/or reported and additional actions that were taken, if any, to treat my son or daughter.

_____
Parent/Guardian Signature

_____
Date

Received by the School on _____ .
Date

_____
Signature of School Official

_____
Title/Capacity

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[1]Section 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."