# Possible Concussion Notification Form: US Youth Soccer Events

Today,_____, 20_____, at the_____,
[Insert Date] [Insert Name of Event]

player_____, showed signs of a possible concussion during practice or
[Insert Player's Name]

competition. US Youth Soccer and Staff want to make you aware of this possibility and signs and symptoms that may arise which require further evaluation and/or treatment.

Please contact a medical doctor or doctor of osteopathy who is trained in concussion treatment and management. Please be advised that a player who shows or showed signs of a concussion may not return to play until we have the signed Concussion Return to Play form (see page 2) from a medical doctor or doctor of osteopathy who is trained in concussion treatment and management. The cost of the signed clearance is not paid by US Youth Soccer.

| | | |
|---|---|---|
| Name of Team | Age Group | Gender |
| Player's Name (Please print) | Date | |
| Player's Signature (If above the age of 18) | Date | |
| Parent/Legal Guardian Signature | Date | |
| Team Official Guardian Signature | Date | |

*By inserting my name and date and returning this Notification Form, I confirm that I have been provided with, and acknowledge that, I have read the information contained in the Form.*

If returning a scanned copy of the signed Form by e-mail, then please send it to: nationaloffice@usyouthsoccer.org

If returning the signed Form by mail, then please send it to the following address:

US Youth Soccer
ATTN: Return to Play Form
P.O. Box 1928
Frisco, TX 75033

# US Youth Soccer Concussion Return to Play Form

This form is adapted from the Acute Concussion Evaluation (ACE) care plan on the U.S. Centers for Disease Control web site www.cdc.gov/injury. All medical providers are encouraged to review this site if they have questions regarding the latest information on the evaluation and care of the athlete following a concussion injury. **Providers, please initial any recommendations that you select.**

Athlete's Name _____ Date of Birth: _____

Club: _____ Team Name: _____

## HISTORY OF INJURY

Person Completing Form (*Circle One*): Athletic Trainer | First Responder | Coach | Parent | Administrator

Date of Injury: _____ ☐ Please see attached information ☐ Please see further history on back of this form

| Did the athlete have: | (Circle one) | Duration / Resolution |
|---|---|---|
| *Loss of consciousness or unresponsiveness?* | YES \| NO | Duration: _____ |
| *Seizure or convulsive activity?* | YES \| NO | Duration: _____ |
| *Balance problem / unsteadiness?* | YES \| NO | IF YES, HAS THIS RESOLVED? YES \| NO |
| *Dizziness?* | YES \| NO | IF YES, HAS THIS RESOLVED? YES \| NO |
| *Headache?* | YES \| NO | IF YES, HAS THIS RESOLVED? YES \| NO |
| *Nausea?* | YES \| NO | IF YES, HAS THIS RESOLVED? YES \| NO |
| *Emotional instability (abnormal laughing, crying, smiling, anger)?* | YES \| NO | IF YES, HAS THIS RESOLVED? YES \| NO |
| *Confusion?* | YES \| NO | IF YES, HAS THIS RESOLVED? YES \| NO |
| *Difficulty concentrating?* | YES \| NO | IF YES, HAS THIS RESOLVED? YES \| NO |
| *Vision Problems?* | YES \| NO | IF YES, HAS THIS RESOLVED? YES \| NO |
| *Other:* | YES \| NO | IF YES, HAS THIS RESOLVED? YES \| NO |

**Signature:** _____ **Date:** _____

## PHYSICIAN RECOMMENDATIONS

This return to play plan is based on today's evaluation.

### RETURN TO SPORTS

PLEASE NOTE:

1. **Athletes must not return to practice or play the same day that their suspected concussion occurred.**
2. **Athletes should never return to play or practice if they still have ANY symptoms of concussion.**
3. **Athletes, be sure your coach/athletic trainer are aware of your injury & symptoms, and have contact information for treating physician.**

### The following are the return to sports recommendations at the present time:

SCHOOL (ACADEMICS): ☐ May return to school now. ☐ May return to school on _____. ☐ Out of school until follow-up visit.

PHYSICAL EDUCATION: ☐ Do NOT return to PE class at this time. ☐ May Return to PE class.

SPORTS:
- ☐ Do not return to sports practice or competition at this time.
- ☐ May begin "Gradual Return To Play Plan".
- ☐ Must return to Physician for final clearance to return to competition.
- ☐ FULL CLEARANCE: Has successfully completed "Gradual Return to Play Plan". May return to full participation.

– *OR* –
- ☐ FULL CLEARANCE: Did not have a concussion. May return to full participation in ALL activities (PE and Sports).

Return to this office on (date/time) _____

Additional Comments: _____ ☐ See further follow-up information on back.

**Medical Office Information** (Please Print/Stamp)

Physician' Name _____ Physician's Phone _____

/ Office Address _____

_____

Physician's Signature _____ (Circle One) , M.D. | D.O Date _____

## Gradual Return to Play Plan

**Return to play should occur in gradual steps beginning with light aerobic exercise only to increase your heart rate (e.g. stationary cycle); moving to increasing your heart rate with movement (e.g. running); then adding controlled contact if appropriate; and finally return to sports competition.**

**Pay careful attention to your symptoms and your thinking and concentration skills at each stage or activity. After completion of each step without recurrence of symptoms, you can move to the next level of activity the next day. Move to the next level of activity only if you do not experience any symptoms at the present level. If your symptoms return, let your health care provider know, return to the first level and restart the program gradually.**

**Day 1:** Low levels of physical activity (i.e. symptoms do not come back during or after the activity).
This includes walking, light jogging, light stationary biking, and light weightlifting (low weight – moderate reps, no bench, no squats).

**Day 2:** Moderate levels of physical activity with body/head movement.
This includes moderate jogging, brief running, moderate intensity on the stationary cycle, moderate intensity weightlifting (reduce time and or reduced weight from your typical routine).

**Day 3:** Heavy non-contact physical activity.
This includes sprinting/running, high intensity stationary cycling, completing the regular lifting routine, non-contact sport specific drills (agility – with 3 planes of movement).

**Day 4:** Sports Specific practice.

**Day 5:** Full contact in a controlled drill or practice.

**Day 6:** Return to competition.