SCOTTSBLUFF PUBLIC SCHOOLS
HEAD INJURY CLEARANCE FORM
Return to Play (PE, recess)

Student Name: _____
Date of Birth: _____
Date of Head Injury: _____

PARENT/GUARDIAN CLEARANCE:

As Parent/Guardian, I grant permission for the above-named student to resume participation in physical activities. I choose not to have the above-named student assessed by a health care professional for this injury. I acknowledge that I have been provided information about the signs and symptoms associated with concussions and potential head injuries and risks involved with sustaining a concussion. I acknowledge that my student has been instructed to report such symptoms immediately to myself, as well one of the school's Concussion Management Team member(s), or teacher, and to remove themselves immediately from all physical activity should such symptoms exist at any time.

_____ _____

Parent/Guardian Signature Date Parent/Guardian Name PRINTED

The Nebraska Concussion Awareness Act: "A licensed health care professional mean a physician or licensed practitioner under the direct supervision of a physician, a certified athletic trainer, a neuropsychologist, or some other qualified individual who (a) is registered, licensed, certified, or otherwise statutorily recognized by the State of Nebraska to provide health care services and (b) is trained in the evaluation and management of traumatic brain injuries among a pediatric population."