SCOTTSBLUFF PUBLIC SCHOOLS CONCUSSION CLEARANCE FORM

Return to Play

Student Name: _____

Date of Birth: Date of Concussion: PARENT/GUARDIAN CLEARANCE: I, the Parent/Guardian of the above-named student grant permission for them to resume participation in athletic activities. I understand that my son's/daughter's return to completion may need to follow a Return to Play progression if ordered by their health care professional. I acknowledge that my son/daughter has been provided information about the signs and symptoms associated with concussions and potential head injuries, risks involved with sustaining a concussion, and is instructed to report such symptoms immediately to myself, as well one of the school's Concussion Management Team member(s), coach, or teacher, and to remove themselves immediately from all athletic activity should such symptoms exist at any time.					
			Parent/Guardian Signature	Date	Parent/Guardian Name PRINTED
			LICENSED HEALTHCA	ARE PROFESSION	ONAL CLEARANCE:
As a licensed healthcare profession injuries among a pediatric population	• •	h the evaluation and management of traumatic brain ne above-named student may:			
	etic activities upon comprecommendations	pletion of the Return to Play Progression per my			
May resume athle	etic activities. No Returr	n to Play Progression needed at this time			
Health Care Professional Signature	Date	Health Care Professional 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."