



Wyoming Soccer Association
777 Overland Trail, Suite 132, Casper, WY 82601
Possible Concussion Notification Form
for Wyoming Soccer Association 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. Wyoming Soccer Association (WSA) and your local club 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 provider (MD, DO, NP, PA) regarding this possible concussion. Please be advised that a player who shows or showed signs of a concussion may not return to play until we have the Concussion Return to Play form (see page 2) from a medical provider (MD, DO, NP, PA). This release is then referred to WSA for final clearance to return to play. The cost of the signed clearance is not paid by WSA.

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 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 email, please send it [to wssa@wyomingsoccer.com](mailto:wssa@wyomingsoccer.com).

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

Wyoming Soccer Association
777 Overland Trail, Suite 132
Casper, WY 82601

Wyoming Soccer Association 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: _____

School: _____

Team: _____

HISTORY OF INJURY Person Completing Form (Select One): Athletic Trainer | First Responder | Coach

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

How did the injury happen?

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

Signature: _____

Date: _____

MEDICAL PROVIDER 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 provider.

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) _____ No follow-up needed.

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

Medical Provider's Office Information

Provider's Name: _____

Phone #: _____

Office Address: _____

Fax #: _____

Medical License#: _____

Provider's Signature _____, M.D. /D.O./ N.P. /P.A. 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.

