

NOTICE TO PARENT / GUARDIAN

ORC 3707.51 and Black Swamp Soccer League policy require any player who exhibits signs, symptoms or behaviors associated with a concussion to be removed from any practice or contest and not permitted to return to play without written medical authorization from a physician (M.D. Or D.O) This form shall serve as the authorization that the medical professional has examined the player and determined that the player has either not been concussed or the player has been released and may return to play in accordance with any restrictions noted or without restriction.

This form is to serve that your child _____ has been removed from a soccer practice or contest today because they have exhibited signs, symptoms or behavior consistent with a concussion. Please understand the coach, administrator or official that has removed your child from play has completed a course recognized by the Ohio Department of Health and has removed your child for their safety. Please consider their concern and pay close attention to your child until you can have them examined by your health care provider. Until they have been released to play by your health care provider they will not be permitted to participate with the team at any level.

Signature of removing official _____

By my signature I understand my child has been removed and will not participate until he/she has been examined and released by a health care professional.

Signature of Parent/Guardian _____

Date _____

MEDICAL AUTHORIZATION TO RETURN TO PLAY

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I, _____, M.D., D.O. Have examined the following player _____ who was removed from a practice/contest due to exhibition of signs, symptoms or behaviors consistent with a concussion. I have determined that the player has/has not been concussed and is cleared to return to play with the following restrictions

Signature of Medical Professional _____

Date _____

Please provide a copy of the information to BSSL president and Club Director