Nebraska Lacrosse High School Concussion Referral AND Return to Participation Form

COACH, ATHLETIC TRAINER or TEAM REPRESENTATIVE: PLEASE FILL OUT THE TOP PORTION OF THIS FORM AND SEND WITH PARENTS/STUDENT ATHLETE TO PHYSICIAN

PHYSICANS/HEALTH CARE PROFESSIONAL (PER LB NE Concussion Awareness Act): PLEASE FILL OUT LOWER PORTION OF FORM AND RETURN ENTIRE FORM TO THE STUDENT-ATHLETE

Athlete's name: _____ **DOB**: _____

Sport: _____ **School**_____ **Previous Head Injuries**: Yes or No

Date of Injury:_____ **Approximate Time of Injury**_____**am/pm**

Signs Observed by Coach:

- ☐ Dazed/confused
- ☐ Lack of coordination
- ☐ Poor reaction time
- ☐ Loss of consciousness
- ☐ Change in personality/mood
- ☐ Pupils not equal/reactive to light, or unable to focus
- ☐ Nystagmus
- ☐ Vomiting
- ☐ Photophobia
- ☐ Fatigue
- ☐ Retrograde amnesia

Symptoms reported by athlete

- ☐ Headache
- ☐ Dizziness
- ☐ Nausea
- ☐ Fatigue
- ☐ Feeling foggy
- ☐ Feeling sluggish
- ☐ Sensitivity to Light
- ☐ Change in sleep
- ☐ Memory/concentration Problems
- ☐ Double/Fuzzy Vision
- ☐ Balance Issues

The following was done to care for and/or treat the athlete:_____

_____

The athlete ***will be restricted from participating until evaluated and cleared to return to play by a licensed health care professional (per the NE Concussion Awareness Act).*** **It is recommended that the athlete not be allowed to return to competition until they have been cleared by a licensed health care professional, are asymptomatic during rest and exertional activities, show no neuro-cognitive impairments on ImPACT post-test (or other neurocognitive evaluation) as evaluated by the attending Licensed Health Care Professional AND completed a supervised return to play progression.**

Health Care Professionals

ImPACT Baseline Testing has been made available to NE Lacrosse. To obtain baseline results and schedule post-injury testing, please contact (or have parent/guardian contact): Rusty McKune, Sports Medicine Program Coordinator, Nebraska Medicine
Phone: 402-250-5720

Physician/Licensed Health Care Professional Report

___ Athlete is cleared to begin a return to play progression no sooner than (DATE): _____. The student-athlete may return to all practices/competition after successfully completing the Nebraska Lacrosse Return to Play Progression.

___Athlete may not return to any activity until after my next examination set for the following date and time:

Date:_____ **Time:**_____

Further Recommendation: _____

Diagnosis: _____

Health Care Professional Name/Signature_____

Office Name and Phone_____

Date_____

Parent/Legal Guardian Release to Participate: ***I have been informed of my son/daughters condition and understand that they have suffered a concussion. I hereby grant my son/daughter permission to return to participation in accordance with the steps outlined on this form.***

_____ _____

Signature of Parent/Legal Guardian **Date**

THIS FORM MUST BE SIGNED BY A PHYSICIAN/LICENSED HEALTH CARE PROFESSIONAL AND PARENT/LEGAL GUARDIAN AND RETURNED TO THE HEAD COACH PRIOR TO AN ATHLETE RETURNING TO ANY ACTIVITY/PRACTICE/COMPETITION.
MANAGERS SHOULD RETAIN THIS DOCUMENT AND PLACE IN THE PLAYERS FOLDER.