Concussion Questions and Contact Information

Player Name: _____ Date: _____

Player Address: _____

City: _____ Zip: _____ County: _____

Parent Phone: _____ Parent Phone: _____

Age: _____ School: _____ School District: _____

Check all that applies:

I participate in:

___ Lacrosse ___ Baseball/Softball ___ Basketball ___ Hockey

___ Football ___ Golf ___ Volleyball ___ Wrestling

___ Track & Field ___ Cross Country ___ Cheerleading ___ Tennis

___ Skiing/Snowboarding ___ Gymnastics ___ Swimming ___ Soccer

___ Other: _____

Have you even been treated or seen for a concussion? _____

If yes, what where you doing and when did it happen: (list all occasions) _____

_____

_____

Have you ever experience concussion symptoms? _____

If yes, did you report them and to whom did you report them to? _____

Emergency Contact Information:

1st Person to Contact Name: _____ Relation: _____

Phone Number: _____

2nd Person to Contact Name: _____ Relation: _____

Phone Number: _____

Doctors Name: _____ Phone Number: _____

By signing this form, I agree that the Elkhorn KWIK STX Lacrosse Club can contact my child's school nurse if they suspect my child has any concussion possibilities.

Parent or Guardian Signature: _____ Date: _____