



**I have read the Ohio Department of Health's Concussion Information Sheet and understand that I have a responsibility to report my/my child's symptoms to coaches, administrators, and health care provider. I also understand that I/my child must have no symptoms before return to play can occur.**

Athlete Name (please print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Ohio Department of Health**

*Violence and Injury Prevention Section*

246 North High Street, 5th Floor

Columbus, OH 43215

(614) 466-2144

<http://www.odh.ohio.gov/concussion>