MINNESOTA HOCKEY COACH
CONCUSSION CERTIFICATION

I have completed training or an annual update to previous training regarding concussions. Attached to this certification is evidence of my completion of the required annual training. I understand what a concussion is and what are the common signs, symptoms and behaviors associated with concussion and concussion type symptoms. I agree I will remove an athlete from all team physical activities if a player sustains a concussion or exhibits concussion type symptoms. I understand it is my responsibility to complete a Minnesota Hockey Concussion Reporting and Medical Clearance To Return To Play Form within 48 hours of receipt of information which indicates a player has sustained a concussion or exhibits concussion type symptoms. I understand that I cannot allow a player to return to team physical activities until I have received a completed Minnesota Hockey Concussion Reporting and Medical Clearance To Return To Play Form which is signed by an appropriate health professional and a parent or legal guardian of the player. I understand that knowingly violating the Youth Rules and Regulations can result in discipline up to and including suspension for up to one year.

Association Name: _____

Coach Name: _____

Signature: _____

Date: _____

District: _____

Team Name: _____

NOTE THAT TRAINING CAN BE COMPLETED ONLINE THROUGH THE CENTER FOR DISEASE CONTROL AT: https://www.cdc.gov/headsup/youthsports/training/index.html. TRAINING FOR OTHER SPORTS WILL SATISFY THE TRAINING REQUIRED FOR THIS CERTIFICATION.

MINNESOTA HOCKEY CONCUSSION REPORTING AND MEDICAL CLEARANCE TO RETURN TO PLAY FORM

Minnesota statute §121A.37 requires that a youth athlete must be removed from physical participation in an athletic activity if they exhibit any signs, symptoms or behaviors consistent with a concussion or is suspected of sustaining a concussion and shall not return to physical activity until he or she no longer exhibits the signs, symptoms or behaviors consistent with a concussion and has been evaluated by a provider trained and experienced in managing concussions and has provided written clearance to participate in the athletic activity. **This form is to be used after an athlete has been removed from an athletic activity due to a concussion or concussion symptoms.**

Player Name: _____ DOB: _____/_____/_____

District: _____ Name of person reporting: _____

Association and Team: _____ Date of Injury: _____/_____/_____

Location of injury/arena: _____

Nature, extent of injuries, and symptoms: _____

Date athlete no longer exhibited symptoms: _____/_____/_____

Print Health Professional Name: _____Title:_____

Name of Clinic of Health Professional: _____ License number: _____
Note: An "Appropriate health professional" means a health professional who is licensed, registered, certified or otherwise authorized to provide medical treatment, trained and experienced in evaluating and managing pediatric concussions, and practicing within that person's medical training and scope of practice.

Address: _____ Phone Number: _____

I HEREBY AUTHORIZE THE ABOVE NAMED ATHLETE TO RETURN TO ATHLETIC ACTIVITY FOR FULL PARTICIPATION WITHOUT RESTRICTION.

Signature: _____Date:____/_____/_____

I AM THE PARENT OR LEGAL GUARDIAN OF THE PLAYER IDENTIFIED ON THIS FORM AND I CONSENT TO THEIR RETURN TO ATHLETIC ACTIVITY WITHOUT RESTRICTION.

Parent/legal guardian name: _____ Date:____/_____/_____

Signature: _____

AT THE END OF THE YEAR A COPY OF THIS FORM SHALL BE PROVIDED TO THE ASSOCIATION PRESIDENT OR DESIGNATED REPRESENTATIVE AND THE USA HOCKEY RISK MANAGER, MINNESOTA DISTRICT