Removal from Sport Letter

Date: _____ Athlete's Name: _____

To whom it may concern,

The athlete named above has been removed from all training, practice and competition activities related to their team in the Soo Minor Baseball Association as they experienced an event that puts them at risk of sustaining a concussion.

They must be assessed by a Medical Doctor or a Nurse Practitioner. They can not return to any team activities until they are cleared by a Medical Doctor or Nurse Practitioner.

The Event occurred on (Date): _____

The Event was reported by: _____

Description of suspected concussion event (what happened):

_____

_____

_____

_____

_____

Red Flag Symptoms the participant demonstrated (Circle all that apply):

- Severe or increasing headache
- Double vision
- Weakness or tingling/burning in arms/legs
- Neck pain or tenderness
- Loss of consciousness
- Deteriorating conscious state
- Seizure or convulsion
- Repeated vomiting
- Increasingly restless, agitated or combative

Signs or Symptoms of a concussion the participant demonstrated (Circle all that apply):

Physical Headache Pressure in head Dizziness Nausea or vomiting Blurred vision Sensitivity to light or sound Ringing in the ears Balance problems Tired or low energy Drowsiness "Don't feel right"	**Cognitive (Thinking)** Not thinking clearly Slower thinking Feeling confused Problems concentrating Problems remembering **Emotional** Irritability (easily upset or angered) Depression Sadness Nervous or anxious
Other (not listed):	**Sleep-related** Sleeping more of less than usual Having a hard time falling asleep

They will not be able to return to unrestricted participation in training, practice or competition until they have received a completed **Medical Assessment Letter** stating they do not have a concussion and may return to regular activities.

If they have been diagnosed with a concussion the **Return to Sport Process** will be implemented. The designated person must receive a completed **Medical Clearance Letter** from a Medical Doctor or a Nurse Practitioner clearing the player to return to regular sport activities after the player has successfully completed each step in the **Graduated Return to Sport Steps**.

Thank-you very much in advance for your understanding. Your designate person to report to during the return to sport process is signed below.

Name (print) _____

Designation _____

Signature _____