**Contact Training and Match Play Club Declaration**

Club Name……………………………………………

Participant Name……………………………………………………………..DOB…………………………………

**PLEASE NOTE –**

*If the answer to any of the following 4 questions is ‘Yes’ 24hrs after completing the mandatory contact training session as referred to in the GRTS protocols, then the player requires further observation and rest and/or a referral for specialist assessment with a Neurologist, Neurosurgeon or Sport & Exercise Physician with an interest in Concussion.*

1. *Are there any neurological or other worrying symptoms on questioning, or signs on examination?*

*Yes ……………. No………….*

1. *Is the player experiencing ongoing symptoms suggestive of concussion?*

*Yes…………… No…………*

1. *The player has NOT successfully fully returned to their usual work or education/school without symptoms?*

*Yes…………… No………..*

1. *Does the player experience any concussion type symptoms when exercising?*

*Yes…………. No………..*

**On behalf of the ………………………………………………………………(Club) I declare that this player has completed the Graduated Return to Sport Protocol (GTRS), the Community Head Injury and Referral Form, and the mandatory two day contact training period has been completed symptom free**

**Name………………………………………………………………………….**

**Position……………………………………………………………………….**

**Signature………………………………………………………………………….Date……………………………………**

**OFFICE USE ONLY: Date Received………………………………..NSWRL Staff………………………………**