TEAM MANAGERS

UPDATED 2022

LETTER FROM CBS BOARD OF DIRECTORS

FORMS

- ANNUAL BACKGROUND CHECKS
- FYSA MEDICAL RELEASE
- FYSA NOTICE OF POSSIBLE HEAD INJURY/CONCUSSION

GAMEDAY

- ROSTER
- LAMINATED PLAYER/COACH PASSES
- GAME REPORTS
- REFEREE FEES
- GAME SCHEDULES & RESCHEDULING

TEAM COMMUNICATION

- TEAM APP/TEAM SNAP
- INCLEMENT WEATHER
- POINTS OF CONTACT
- TRAINING FEES
- PICTURES & VIDEOS FOR SOCIAL MEDIA

TOURNAMENTS

- MEDICAL RELEASES
- TEAM BUDGETING
- TOURNAMENT CHECK-IN

On behalf of Central Brevard Soccer, thank you for becoming a team manager.

Since 1982, our goal is to provide a positive experience for all players that enable each child to grow in the sport, while learning valuable lessons during development that last throughout their youth years.

Your willingness to contribute to this is appreciated.

Most Sincerely,

CENTRAL BREVARD SOCCER

BOARD OF DIRECTORS

ALL COACHES & VOLUNTEERS ARE REQUIRED TO COMPLETE BACKGROUND CHECKS ANNUALLY

- ONCE ASSIGNED AS A TEAM MANAGER IN GOT SPORT, EACH YEAR YOU MUST COMPLETE THE FOLLOWING IN THE SYSTEM:
  - BACKGROUND CHECK
  - SAFESPORT CONCUSSION TRAINING
  - HEADS-UP TRAINING
- BREVARD PARKS & REC BACKGROUND CHECK IS REQUIRED EVERY FIVE YEARS

ALL OF THESE MUST BE COMPLETE BEFORE THE TEAM MANAGER CAN BE ADDED TO THE ROSTER

Florida Youth Soccer Association

PARENT/GUARDIAN CONSENT AND PLAYER MEDICAL RELEASE FORM

Player's Name:_____Date of Birth:_____Gender:_____

Address:_____City:_____State:_____Zip:_____

EMERGENCY INFORMATION

Father's Name:_____Home Phone:_____Work Phone: _____

Mother's Name:_____Home Phone:_____Work Phone: _____

In an **emergency, when parents cannot be reached, please contact:**

Name:_____Home Phone:_____Work Phone: _____

Name:_____Home Phone:_____Work Phone: _____

Allergies:_____

Other Medical Conditions: _____

Player's Physician:_____Home Phone:_____Work Phone: _____

Medical and/or Hospital Insurance Company:_____Phone:_____

Policy Holder:_____Policy If:_____Group #:_____

PLEASE COPY BOTH SIDES OF YOUR HEALTH INSURANCE CARD AND ATTACH TO THIS FORM

PARENT/GUARDIAN CONSENT AND MEDICAL RELEASE

Recognizing the possibility of injury or illness, and in consideration for FYSA and US Youth Soccer and members of US Youth Soccer accepting my son/daughter as a player in the soccer programs and activities of US Youth Soccer and its members (the "Programs"), I consent to my son/daughter participating in the Programs. Further, I hereby release, discharge, and otherwise indemnify FYSA and US Youth Soccer, its member organizations and sponsors, their employees, associated personnel, and volunteers, including the owner of fields and facilities utilized for the Programs, against any claim by or on behalf of my player son/daughter as a result of my son's/daughter's participation in the Programs and/or being transported to or from the Programs.

My player son/daughter has received a physical examination by a licensed medical doctor and has been found physically capable of participating in the sport of soccer. I have provided written notice, which is submitted in conjunction with this release and attached hereto, setting forth any specific issue, condition, or ailment, in addition to what is specified above, that my child has or that may impact my child's participation in the Programs. I give my consent to have an athletic trainer and/or licensed medical doctor or dentist provide my son/daughter with medical assistance and/or treatment and agree to be financially responsible for the reasonable cost of any such assistance and/or treatment.

_____ _____

Signature of Parent/Guardian Date

Possible Concussion Notification Form: US Youth Soccer Events

Today,_____, 20_____, at the_____,
[Insert Date] [Insert Name of Event]

player_____, showed signs of a possible concussion during practice or
[Insert Player's Name]

competition. US Youth Soccer and Staff want to make you aware of this possibility and signs and symptoms that may arise which require further evaluation and/or treatment.

Please contact a medical doctor or doctor of osteopathy who is trained in concussion treatment and management. Please be advised that a player who shows or showed signs of a concussion may not return to play until we have the signed Concussion Return to Play form (see page 2) from a medical doctor or doctor of osteopathy who is trained in concussion treatment and management. The cost of the signed clearance is not paid by US Youth Soccer.

Name of Team	Age Group	Gender
Player's Name (Please print)	Date	
Player's Signature (If above the age of 18)	Date	
Parent/Legal Guardian Signature	Date	
Team Official Guardian Signature	Date	

By inserting my name and date and returning this Notification Form, I confirm that I have been provided with, and acknowledge that, I have read the information contained in the Form.

If returning a scanned copy of the signed Form by e-mail, then please send it to: nationaloffice@usyouthsoccer.org

If returning the signed Form by mail, then please send it to the following address:

US Youth Soccer
ATTN: Return to Play Form
P.O. Box 1928
Frisco, TX 75033

US Youth Soccer Concussion Return to Play Form

This form is adapted from the Acute Concussion Evaluation (ACE) care plan on the U.S. Centers for Disease Control web site www.cdc.gov/injury. All medical providers are encouraged to review this site if they have questions regarding the latest information on the evaluation and care of the athlete following a concussion injury. **Providers, please initial any recommendations that you select.**

Athlete's Name _____ Date of Birth: _____

Club: _____ Team Name: _____

HISTORY OF INJURY

Person Completing Form (*Circle One*): Athletic Trainer | First Responder | Coach | Parent | Administrator

Date of Injury: _____ ☐ Please see attached information ☐ Please see further history on back of this form

Did the athlete have:	(Circle one)	Duration / Resolution
Loss of consciousness or unresponsiveness?	YES | NO	Duration: _____
Seizure or convulsive activity?	YES | NO	Duration: _____
Balance problem / unsteadiness?	YES | NO	IF YES, HAS THIS RESOLVED? YES | NO
Dizziness?	YES | NO	IF YES, HAS THIS RESOLVED? YES | NO
Headache?	YES | NO	IF YES, HAS THIS RESOLVED? YES | NO
Nausea?	YES | NO	IF YES, HAS THIS RESOLVED? YES | NO
Emotional instability (abnormal laughing, crying, smiling, anger)?	YES | NO	IF YES, HAS THIS RESOLVED? YES | NO
Confusion?	YES | NO	IF YES, HAS THIS RESOLVED? YES | NO
Difficulty concentrating?	YES | NO	IF YES, HAS THIS RESOLVED? YES | NO
Vision Problems?	YES | NO	IF YES, HAS THIS RESOLVED? YES | NO
Other:	YES | NO	IF YES, HAS THIS RESOLVED? YES | NO

Signature: _____ **Date:** _____

PHYSICIAN RECOMMENDATIONS

This return to play plan is based on today's evaluation.

RETURN TO SPORTS

PLEASE NOTE:

1. **Athletes must not return to practice or play the same day that their suspected concussion occurred.**
2. **Athletes should never return to play or practice if they still have ANY symptoms of concussion.**
3. **Athletes, be sure your coach/athletic trainer are aware of your injury & symptoms, and have contact information for treating physician.**

The following are the return to sports recommendations at the present time:

SCHOOL (ACADEMICS): ☐ May return to school now. ☐ May return to school on _____. ☐ Out of school until follow-up visit.

PHYSICAL EDUCATION: ☐ Do NOT return to PE class at this time. ☐ May Return to PE class.

SPORTS:
- ☐ Do not return to sports practice or competition at this time.
- ☐ May begin "Gradual Return To Play Plan".
- ☐ Must return to Physician for final clearance to return to competition.
- ☐ FULL CLEARANCE: Has successfully completed "Gradual Return to Play Plan". May return to full participation.

- OR - ☐ FULL CLEARANCE: Did not have a concussion. May return to full participation in ALL activities (PE and Sports).

Return to this office on (date/time) _____

Additional Comments: _____ ☐ See further follow-up information on back.

Medical Office Information (Please Print/Stamp)

Physician' Name _____ Physician's Phone _____

/ Office Address _____

_____

Physician's Signature _____ (Circle One) , M.D. | D.O Date _____

Gradual Return to Play Plan

Return to play should occur in gradual steps beginning with light aerobic exercise only to increase your heart rate (e.g. stationary cycle); moving to increasing your heart rate with movement (e.g. running); then adding controlled contact if appropriate; and finally return to sports competition.

Pay careful attention to your symptoms and your thinking and concentration skills at each stage or activity. After completion of each step without recurrence of symptoms, you can move to the next level of activity the next day. Move to the next level of activity only if you do not experience any symptoms at the present level. If your symptoms return, let your health care provider know, return to the first level and restart the program gradually.

- **Day 1:** Low levels of physical activity (i.e. symptoms do not come back during or after the activity).
  This includes walking, light jogging, light stationary biking, and light weightlifting (low weight – moderate reps, no bench, no squats).
- **Day 2:** Moderate levels of physical activity with body/head movement.
  This includes moderate jogging, brief running, moderate intensity on the stationary cycle, moderate intensity weightlifting (reduce time and or reduced weight from your typical routine).
- **Day 3:** Heavy non-contact physical activity.
  This includes sprinting/running, high intensity stationary cycling, completing the regular lifting routine, non-contact sport specific drills (agility – with 3 planes of movement).
- **Day 4:** Sports Specific practice.
- **Day 5:** Full contact in a controlled drill or practice.
- **Day 6:** Return to competition.

GAMEDAY

- COACH WILL NEED TWO ROSTER COPIES PER GAME
- MANAGER CAN BE LISTED ON ROSTER ONCE BACKGROUND CHECKS ARE APPROVED
- ALL PLAYERS & COACHES NEED OFFICIAL LAMINATED PLAYER CARDS WITH CURRENT PHOTOS A KEYRING WITH PLAYER CARDS IN ALPHABETICAL ORDER IS RECOMMENDED
- GAME REPORTS ARE REQUIRED WITH SOME LEAGUES. IF REQUIRED, TWO COPIES ARE NEEDED PER GAME. GAME REPORTS ARE AVAILABLE WITHIN LEAGUE/TEAM ONLINE SCHEDULES ON GOTSPORT. MATCH/GAME REPORTS THEN NEED TO BE UPLOADED INTO THE SYSTEM ONCE RESULTS HAVE BEEN DETERMINED
- COACHES ARE RESPONSIBLE FOR REPORTING BLACK-OUT DATES TO THE DOC'S AT TIME OF LEAGUE DECLARATION. ONCE GAME SCHEDULES ARE PUBLISHED, TEAMS SHOULD AVOID CANCELLING IF AT ALL POSSIBLE. IF CBS TEAMS RESCHEDULE OR CANCEL GAMES, THE TEAM WILL BE RESPONSIBLE FOR PAYING ANY CANCELLATION FEES ISSUED. COACHES SHOULD REPORT GAME CONFLICTS TO THEIR DOC

REFEREE FEES

- REFEREE FEES ARE DETERMINED BY THE LEAGUES/TOURNAMENTS WE PLAY IN. THESE RATES ARE PUBLISHED ONLINE WITH THE LEAGUE WEBSITE. PLAYER REGISTRATION FEES INCLUDE LEAGUE REFEREE FEES (IF TEAMS PLAY IN MULTIPLE LEAGUES, ONLY THE FIRST LEAGUE IS PAID FOR BY CBS)
- THE CBS TREASURER WILL DISPERSE REF FEES EACH SEASON. FEES ARE REQUIRED TO BE PAID AT PLAYER CHECK-IN ON GAMEDAY AND RETURNED TO THE CLUB IF THE GAME IS NOT PLAYED

TEAM COMMUNICATION

- AS TEAM MANAGER, YOU'LL ASSIST THE HEAD COACH IN COMMUNICATING WITH THE TEAM
- MOST TEAMS USE A SOCCER-SPECIFIC MOBILE APP FOR COMMUNICATING
- TEAM COMMUNICATION INCLUDES TRAINING SCHEDULES, GAME SCHEDULES, TEAM UPDATES, AND ANY UPDATES THAT NEED TO BE ANNOUNCED QUICKLY (FIELD CHANGES, INCLEMENT WEATHER, ETC)
- DOC SHOULD BE INCLUDED IN GROUP CHAT

INCLEMENT WEATHER

- IF YOU CAN HEAR THUNDER, YOU ARE WITHIN REACH OF LIGHTNING
- ACTIVITIES SHOULD BE SUSPENDED UNTIL 30 MINUTES AFTER THE LAST STRIKE OF LIGHTNING IS SEEN (OR AT LEAST 10 MILES AWAY) AND AFTER THE LAST SOUND OF THUNDER IS HEARD
- THIS 30-MINUTE CLOCK RESTARTS FOR EACH LIGHTNING FLASH WITHIN 10 MILES AND EACH TIME THUNDER IS HEARD
- **THERE IS NO EXCEPTION TO THIS RULE**. EVERYONE, INCLUDING PLAYERS, COACHES, AND SPECTATORS, ARE TO TAKE IMMEDIATE SHELTER

POINTS OF CONTACT (POC)

- YOUR HEAD COACH WILL BE YOUR FIRST POC
- THE COMP DIRECTOR OF COACHING WILL BE YOUR SECOND POINT OF CONTACT
- IF FURTHER ASSISTANCE IS NEEDED, PLEASE REACH OUT TO THE BOARD OF DIRECTORS

TRAINING FEES

- THE COACHES ARE COMPENSATED BY PLAYER TRAINING FEES
- DOC'S APPROVE THE MONTHLY TRAINING FEE RATE AND THESE FEES ARE PAID DIRECTLY TO THE COACH
- FEES CAN BE PAID MONTHLY OR BY SEASON
- TEAM MANAGERS OFTEN ASSIST IN COLLECTING THESE FEES

PICTURES & VIDEOS

- PICTURES AND VIDEOS ARE USED FOR SOCIAL MEDIA & WEBSITE MARKETING
- IF ANY PLAYERS HAVE ELECTED **NOT TO PARTICIPATE** IN THEIR PICTURES/VIDEOS BEING USED ONLINE, THOSE PLAYERS SHOULD NOT PARTICIPATE IN TEAM PICTURES
- FAMILIES ARE ENCOURAGED TO SEND PICTURES & VIDEOS TO THE CLUB'S SOCIAL MEDIA TEAM
- IF YOU'RE COMPETING IN PLAYOFFS OR TOURNAMENTS, BE SURE TO SEND THE INFO SO YOUR TEAM CAN BE RECOGNIZED
- BIRTHDAYS & SPECIAL ACHIEVEMENTS CAN ALSO BE ANNOUNCED BY THE CLUB IF THE INFO IS PROVIDED TO THE SOCIAL MEDIA TEAM

TOURNAMENTS

- LEAGUES & TOURNAMENT HOSTS WILL REQUIRE MEDICAL RELEASES. TEAM MANAGERS WILL BE ASKED TO BE THE RECEIVING POC FOR THESE AS PART OF TOURNAMENT REGISTRATION COPIES OF THESE SHOULD BE AVAILABLE AT EACH TEAM EVENT. A FYSA MEDICAL RELEASE IS INCLUDED IN THIS PACKET
- TEAMS CAN CHOOSE TO PARTICIPATE IN TOURNAMENTS. ALL TOURNAMENT COSTS WILL BE THE RESPONSIBILITY OF THE TEAM TO PAY

BUDGETING

- THE COACH SHOULD INFORM THE TEAM OF PLANNED TOURNAMENTS SO FAMILY PLANNING CAN ENSURE ATTENDANCE
- TOURNAMENT FEES ARE REQUIRED AT THE TIME OF TEAM REGISTRATION AND SHOULD BE PAID ACCORDINGLY
- IT'S CUSTOMARY FOR THE COACH TO RECEIVE COMPLIMENTARY ACCOMMODATIONS (AT THE SAME HOTEL THE TEAM IS STAYING IN) INCLUDED IN THE TEAM BUDGET IF AN OVERNIGHT STAY IS REQUIRED

TOURNAMENT CHECK-IN

- TOURNAMENT CHECK-IN IS USUALLY REQUIRED THE NIGHT BEFORE THE TOURNAMENT STARTS. A COACH OR APPROVED VOLUNTEER WILL NEED TO BE PRESENT FOR VALIDATION OF THE ROSTER, PLAYER/COACH PASSES, **AND MEDICAL RELEASES** BEFORE THE TEAM CAN PARTICIPATE. CHECK WITH THE TOURNAMENT HOST FOR CHECK-IN PROCEDURES