

## **Attachment G**

Parent Weekly Surveillance Report

Public Reporting burden of this collection of information is estimated at 3 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NW, MS D-74, Atlanta, GA 30333; Attn: PRA (0920-XXXX).

Date \_\_\_ / \_\_\_ / \_\_\_

### Weekly survey: Parent

**A. In the past week, has your child had any hits to his/her head or body that occurred during a soccer practice or game AND then developed any of the following symptoms?**

**YES                  NO**

1. Headache
2. "Pressure in head"
3. Nausea or vomiting
4. Dizziness
5. Blurred vision
6. Balance problems
7. Sensitivity to light
8. Sensitivity to noise
9. Feeling slowed down
10. Feeling like "in a fog"
11. "Don't feel right"
12. Difficulty concentrating
13. Difficulty remembering
14. Fatigue or low energy
15. Confusion
16. Drowsiness
17. Trouble falling asleep

18. More emotional

19. Irritability

20. Sadness

21. Nervous or anxious

22. Loss of consciousness (passed out)

i. How many minutes were you unconscious (passed out)? \_\_\_\_\_ minutes

**B. In how many games did your child see playing time this week? \_\_\_\_\_**

**C. How many soccer practices did your child participate in this week? \_\_\_\_\_**