Post Head Injury/ Concussion Initial Return to Participation

Athlete Name: _____DOB: _____/_____/____ Injury Date:_____/_____/_____
I (treating physician) certify that the above listed athlete has been evaluated for a concussive head injury, and currently is/has: (Please circle all that apply)

Asymptomatic
Normal neurological exam
Off medications related to this concussion
Neuropsychological testing (as available) has returned to baseline

The athlete named above is cleared to begin a supervised graded return to play protocol (outline below). If the athlete experiences a return of any of his/her concussion symptoms while attempting a graded return to play, the athlete is instructed to stop play immediately and notify a parent, athletic trainer or coach.

Physician Name: _____ Signature/Degree: _____
Phone: _____ Fax: _____ Today's Date: _____

Graded Return to Play Protocol

Each step, beginning with step 2, should take at least 24 hours to complete. If the athlete experiences a return of any concussion symptoms they must immediately stop activity, wait at least 24 hours or until asymptomatic, and drop back to the previous asymptomatic level. This protocol must be performed under supervision, please initial and date the box next to each completed step. Once the athlete has completed full practice i.e. stage 5, please sign and date below and return this form to the athlete's physician (MD/DO) for review and request the physician complete the return to competition form for the athlete to resume full activity.

Rehabilitation stage	Functional exercise at each stage	Objective	Date completed	Initials
1. No Activity	Rest; physical and cognitive	Recovery	Noted above	Signed above
2. Light aerobic exercise	Walking, swimming, stationary bike, HR<70% maximum; no weight training	Increased heart rate		
3. Sport-specific exercise	Non-contact drills	Add movement		
4. Non-contact training	Complex (non-contact) drills/practice	Exercise, coordination and cognitive load		
5. Full contact practice	Full contact practice	Restore confidence and simulate game situations		
6. Return to full activity	Return to competition	**After completion of the steps above; Form must be completed by physician**		

I attest the above named athlete has completed the graded return to play protocol as dated above.
Athletic Trainer/ Coach/ Parent
Name: _____ Date _____ Phone Number_____

Return to Competition Affidavit

Athlete's Name: _____Date of Birth: _____/_____/_____ Injury Date: _____/_____/_____
Formal Diagnosis: _____ Sport: _____
I certify that I have reviewed the signed graded return to activity protocol provided to me on behalf of the athlete named above and have personally examined this athlete.
This athlete is cleared for a complete return to **full-contact physical activity** as of _____/_____/_____.
This athlete is instructed to stop play immediately and notify a parent, licensed athletic trainer or coach and to refrain from activity should his/her symptoms return.
Physician Name: _____
Physician Signature:_____ License No.: _____
Phone: (_____)_____ Fax: (_____)_____ E-mail: _____
Date: _____/_____/_____