POST CONCUSSION RETURN TO PLAY- Step 1

This completed form must be kept on file at the student-athlete's school.

Student Name: _____ School: _____
DOB: ___/___/_____

Sport: _____ Date of Injury: ___/___/____
Date Returned to school: ___/___/____

I attest that _____ *has completed the graded Return-to-Learn protocol through Step 6 and has been symptom free for 24 hours as dated above.*

Approved School Contact* Name: _____

Title/Position: _____

Signature: _____

Date: ___/___/_____ Phone: (____)_____ email: _____

The student-athlete named above is cleared to begin a graded return-to-play protocol (outlined on page 2) **under the Approved School Contact as of the date indicated below.**

Date cleared for Graded Return-to-Play Protocol: ___/__/_____

If the student-athlete experiences a return of any of his/her concussion symptoms while attempting a graded return to play, the student-athlete is instructed to stop play immediately and notify a parent, licensed athletic trainer or coach.

Approved School Contact* Name: _____
Please print name
Signature/Credentials: _____

Phone: (____) _____ Fax: (____) _____
Date: ___/___/_____

***** *Approved School Contact is that person designated by the school to approve the Graded Return to non-contact physical activities. If the student develops symptoms during Step 2 they should be evaluated by a Healthcare Provider.*

POST CONCUSSION RETURN TO PLAY- Step 2

Graded Return-to-Play (Non-Contact Drills) Protocol

This completed form must be kept on file at the student-athlete's school.

To begin the Return to Play Step 2 the student athlete should have completed the Step 6 of the Return to Learn Protocol and must have been symptom free for 24 hours. Each step listed below should take at least 24 hours to complete. If the athlete experiences a return of any concussion symptoms he/she 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 of the Approved School Contact**. Please initial and date the box next to each completed step.

Once the athlete has completed non-contact training (i.e. stage 3 below), please sign and date below and return this form to the student-athlete's healthcare provider for review and request that the healthcare provider complete the return to full contact physical activity form (Step 3) for the athlete to resume full activity.

Rehabilitation Stage	Functional Exercise at Each Stage	Objective	Date Completed	Initials
1. Aerobic conditioning	Walking, swimming, stationary bike, **Intensity**: 4 out of 10 **Duration**: no more than 30 minutes	Increased heart rate		
2. Sport-specific drills	Non-contact drills **Intensity**: 5-6 out of 10 **Duration**: no more than 60 minutes	Add movement		
3. Non-contact training drills	Complex (non-contact) drills/practice; can initiate resistance training. No head contact or body impact. **Intensity**: 7 out of 10 **Duration**: no more than 90 minutes	Exercise, coordination and cognitive load		

Intensity levels: 1 = very easy; 10 = very hard

I attest that _____ has completed the graded return-to-play protocol (non-contact drills) as dated above.

Approved School Contact* Name: _____

Signature: _____

Date: ___/___/_____ Phone: (____)_____(if ATC) AT License Number: _____

***** *Approved School Contact is that person designated by the school to approve the Graded Return to non-contact physical activities. If the student develops symptoms during Step 2 they should be evaluated by a Healthcare Provider.*

POST CONCUSSION
RETURN TO PLAY- Step 3

RETURN TO FULL CONTACT PHYSICAL ACTIVITY

This completed form must be kept on file at the student-athlete's school.

Return to Play Affidavit

Student-Athlete's Name: _____

Date of Birth: ____/____/_____ Injury Date: ____/____/_____

Formal Diagnosis: _____

School: _____

Sport: _____

I certify that I have reviewed the signed Return-to-Learn** and Post Concussion Return-to-Play forms Step 1 and Step 2 (pages 1 and 2) provided to me on behalf of the athlete named above. This athlete is cleared for a complete return to full-contact physical activity as of ____/____/_____.

This student-athlete is instructed to stop play immediately and notify a parent, licensed athletic trainer or coach and refrain from activity should his/her symptoms return.

Healthcare Provider* Name: _____

Healthcare Provider* Signature: _____
License No: _____

Phone: (_____) _____ Fax: (_____) _____

E-mail: _____
Date: ____/____/_____

*Health care provider as defined in Act 68, Sec. 2.(4)
** Return to Learn Protocol is recommended, not required by Act 68