



# Post Head Injury/Concussion Initial Return to Participation

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This form is to be completed by an appropriate health care provider (AHCP-MD/DO) trained in the latest concussion evaluation and management protocols as defined in FHSAA policy 40.2 for any student-athlete that has sustained a concussion and must be kept on file at the student-athlete's school. The choice of AHCP remains the decision of the parent/guardian or responsible party of the student-athlete.

Athlete Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Injury Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sport: \_\_\_\_\_ School: \_\_\_\_\_ Level (Varsity, JV, etc.): \_\_\_\_\_

I (treating physician) certify that the above listed athlete has been evaluated for a concussive head injury, and currently is/has:  
**(All Boxes MUST be checked before proceeding)**

Asymptomatic  Normal neurological exam

Off medications related to this concussion  Returned to normal classroom activity

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Yes *or*  N/A      Neuropsychological testing (as available) has returned to baseline

The athlete named above is cleared to begin a graded return to play protocol (outline below) under the supervision of an athletic trainer, coach or other health care professional as of the date indicated 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, licensed athletic trainer or coach.

By signing below, I certify that I am a medical doctor (MD/DO) familiar with the most current 2016 Consensus Statement on Concussion in Sport and the tools used for evaluation (ex. SCAT5). This information will be used to guide return to play progression (page 1) and final clearance to return to competition.

Physician Name: \_\_\_\_\_ Signature/Degree: \_\_\_\_\_ MD/DO

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## Graded Return to Play Protocol

After a brief period of initial rest (24-48 hr), symptom-limited activity can begin while staying below a cognitive and physical exacerbation threshold.

Once concussion-related symptoms have resolved, the athlete should continue to proceed to the next level if he/she meets all criteria without recurrence of symptoms. Generally each step should take at least 24 hrs, however, this time frame may vary with player age, history, level of sport, etc., and management must be individualized.

Rehabilitation stage	Functional exercise at each stage	Objective	Date completed	Initials
<b>1. Symptom limited activity</b>	Daily activities that do not provoke symptoms	Gradual reintroduction of work/school activities	Noted above	Signed above
<b>2. Light aerobic exercise</b>	Walking, swimming, stationary bike, HR<70% maximum; no weight training	Increased heart rate		
<b>3. Sport-specific exercise</b>	Non-contact drills, running drills: no impact	Add movement		
<b>4. Non-contact training</b>	Complex (non-contact) drills/practice	Exercise, coordination and cognitive load		
<b>5. Full contact practice</b>	Full contact practice, normal activities	Restore confidence and simulate game situations		
<b>6. Return to full activity</b>	Return to competition	<b>After completion of the steps above; Form AT18, Page 2 must be completed by physician</b>		

I attest the above named athlete has completed the graded return to play protocol as dated above.

Athletic Trainer / Coach Name: \_\_\_\_\_ AT License Number: \_\_\_\_\_ Phone: \_\_\_\_\_

Athletic Trainer / Coach Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician Reviewed:  _____
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Florida High School Athletic Association

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## Return to Competition Affidavit

Student-Athlete's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Injury Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Formal Diagnosis: \_\_\_\_\_

School: \_\_\_\_\_

Sport: \_\_\_\_\_

I certify that I have reviewed the signed graded return to activity protocol 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 to refrain from activity should his/her symptoms return.**

Physician Name: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ MD/DO License No.: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

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

*By signing above, I certify that I am a medical doctor (MD/DO) familiar with the most current 2016 Consensus Statement on Concussion in Sport and the tools used for evaluation (ex: SCAT5). This information will be used to guide return to play progression (page 1) and final clearance to return to competition.*