Seattle Children's HOSPITAL • RESEARCH • FOUNDATION | Orthopedics and Sports Medicine

CONCUSSION RETURN TO PLAY MEDICAL RELEASE

Take this form to your Licensed Health Care Provider. It must be completed by the appropriate medical providers and returned to the onsite Athletic Trainer before returning to play. The Lystedt Law states that the athlete may not return to play until evaluated by a licensed health care provider trained in the evaluation and management of concussion and receives written clearance to return to play from that health care provider. The Seattle Sport Concussion Program and the WIAA state that appropriate medical providers include MD, DO, PA, and ARNP trained in the evaluation and management of concussion.

INJURY DETAILS – TO BE COMPLETED BY ATHLETIC TRAINER OR TREATING HEALTH CARE PROVIDER

Student-athlete name: _____ Date of Birth: _____/_____/_____

School: _____ Grade: _____ Sport:_____ Date of Injury: _____/_____/_____

At the present time, the student is:
- ☐ Symptom-free at rest
- ☐ Symptom-free with exertion
- ☐ NOT symptom-free at rest
- ☐ NOT symptom-free with exertion

Description of injury/comments: _____

_____

Completed by (Printed name): _____ Signature: _____ Date: _____/_____/_____

HEALTH CARE PROVIDER RECOMMENDATIONS – VALID FORM MUST BE COMPLETED AND SIGNED

Date of Health Care Provider appointment: _____/_____/_____

Please note:
- Athlete is not allowed to return to participation on the same day of the injury.
- Athletes should never return to physical activity (including PE and club/recreational sports) if still symptomatic.
- This return-to-participation plan is based on today's evaluation, and deciding to provide clearance releases athlete back to the care of the Athletic Trainer.

ACADEMICS:

- ☐ Student-athlete may return to school now
- ☐ Student-athlete may return to school on_____/_____/_____

Classroom accommodations: _____

PHYSICAL ACTIVITY:

- ☐ Student-athlete is **not cleared** to participate in any physical activity, and is:
  - ☐ Being referred for further testing/evaluation to: _____on _____/_____/_____
  - ☐ To be seen again by treating provider on _____/_____/_____
  - ☐ To be reassessed via phone/email conversation on _____/_____/_____ with treating provider.
- ☐ Student-athlete is **cleared** and ready to begin monitored return-to-participation protocol once asymptomatic for 24 hours
- ☐ Student-athlete is **cleared** for full participation. They have **completed** the return-to-participation progression under my supervision without any recurrence of symptoms.

Additional comments/instructions: _____

Direct Provider phone number/email for AT to contact: _____

Health Care Provider Signature: _____ Name (please print): _____

Graduated, Step-wise Return-to-Participation Progression: *Only one step may be completed each day, under supervision of the Athletic Trainer.*

1. **Symptom-limited activity (with initial 24-48 hour physical and cognitive rest period)**: *Athlete is encouraged to participate in daily activities that do not provoke symptoms. Schoolwork and activities can be gradually reintroduced.*
   Before progressing to the next stage, student-athlete must be able to attend school full time with no returning symptoms.
2. **Light aerobic exercise**: *Walking/jogging or stationary biking at low intensity. No weight lifting or resistance training.*
3. **Sport-specific exercise**: *Sprinting, sport-specific training and agility drills, etc. No helmets or equipment. No head impact activities.*
4. **Exertional non-contact training**: *More complex sport-specific drills in full equipment. May start weight or resistance training.*
5. **Exertional full-contact practice**: *Return to practice as normal with no restrictions.*
6. **Cleared for full participation/competition**.