CONCUSSION RELEASE TO PARTICIPATION

Student Name: _____ **Date:** _____

Sport: _____ **Grade:** _____ **Number of Past Concussions:** _____

Brief description of how injury occurred and/or why concussion is suspected:

_____

HEALTH CARE PROVIDER SECTION

*Per Indiana Code 20-34-7, a student athlete who is suspected of suffering a head concussion may not return to play until the student athlete has been evaluated by a **licensed health care provider trained in the evaluation and management of concussions,** receives a written clearance to return to play, and at least twenty-four (24) hours has passed from the initial injury.*

I have evaluated the above mentioned athlete and it is my professional judgment that:

_____ Athlete is **NOT CLEARED** to return to sports practice, physical education, or conditioning drills. Follow up evaluation is scheduled on: _____

_____ Athlete may begin Return-to-Play protocol as directed below, **MUST RETURN** to physician for final clearance to full competition.

_____ Athlete **MAY BEGIN** Return-to-Play protocol as directed below. Once completed student is cleared for full participation

Return to Play Protocol

Step 1: May participate in light activity on the following date: _____

(10 minutes on an exercise bike, walking or light jogging; but no weight lifting, jumping or hard running)

Step 2: May participate in moderate activity on the following date: _____

(Moderate intensity activity on an exercise bike, jogging or weight lifting for between 30-40 minutes)

Step 3: May participate in heavy; non-contact physical activity on the following date: _____

(Sprinting, running, high-intensity exercise bike, weight lifting; but no contact sports for over 40 minutes)

Step 4: May return to full practice on the following date: _____

Step 5: May return to full game play on the following date: _____

***Each step of the Return-to-Play protocol must be completed on a separate day.** If any signs and/or symptoms of a concussion occur during any step, the student must return to the previous step and return for follow-up with the licensed healthcare provider.

Health Care Provider Signature: _____

Health Care Provider Name: _____**Date**: _____

Health Care Provider Telephone: _____