BVSD Return to School/Play after Concussion Form

Section 2 is to be completed for ALL students; Section 3 is required for a student athlete's Graduated Return to Play process to begin.

Please ensure a copy of this form is turned into your school's health room.

Student Name: ______________________________ DOB: ______________

School: ______________________________ Grade: ______________

Date of Injury: ______________ Date of HCP Visit: ______________

SECTION 1: INJURY DETAILS

DESCRIPTION OF INJURY: (How did injury occur? Initial symptoms?)

Printed Name: ______________________________ Date: ______________

SECTION 2: INITIAL EVALUATION (To be completed by HCP)

_____ (initial) Student has been diagnosed with a concussion. Academic adjustments should be determined by school staff and provided until symptoms have resolved. Suggested date to return to school: ______________.

_____ (initial) Student should be re-evaluated on (Date) ______________.

Note: All physical activity (P.E., recess, etc.) will be restricted until the student is cleared.

SECTION 3: RETURN TO PLAY PERMISSION (To be completed by HCP)

I have examined the above-named student athlete following his/her injury and have determined the following:

_____ (initial) In my professional judgment, it is safe for the student to return to play in interscholastic sports or intramural athletics and permission is granted for the student to begin the Graduated Return to Play process. NOTE: The Return to Play protocol will not progress until the student has completed the Return to Learn Protocol.

_____ (initial) Permission is **NOT** granted for the student to begin the Graduated Return to Play process until they have been re-evaluated.

RE-EVALUATION DATE: ______________

Signature of Health Care Provider: ______________________________

Printed Name of Health Care Provider: ______________________________ **Date:** ______________

Office Phone: ______________ **Email Address:** ______________________________

_____ (initial) I understand the implications of concussion in youth and have been educated on the management of my child's concussion. I give my permission for my child to begin the Graduated Return to Play process when they are free of concussion symptoms and are no longer receiving academic adjustments.

Signature of Parent: ______________________________ **Date:** ______________

Printed Name of Parent: ______________________________