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Ohio High School Athletic Association
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ohsaa.org

MEDICAL AUTHORIZATION TO RETURN TO PLAY WHEN A STUDENT HAS BEEN REMOVED DUE TO A SUSPECTED CONCUSSION

Ohio State Law as well as NFHS rules and OHSAA policy require a student who exhibits signs, symptoms or behaviors associated with concussion to be removed from a practice or contest and **not permitted to reenter practice or competition on the same day as the removal.** Thereafter, **written medical authorization from a physician (M.D. or D.O.)** or another qualified licensed medical provider, who works in consultation with, collaboration with or under the supervision of an M.D. or D.O. or who is working pursuant to the referral by an M.D. or D.O., AND is authorized by the Board of Education or other governing board, **is required to grant clearance for the student to return to participation.** This form shall serve as the authorization that the physician or licensed medical professional has examined the student, and has cleared the student to return to participation. The physician or licensed medical professional must complete this form and submit to a school administrator prior to the student's resumption of participation in practice and/or a contest. **To reiterate, this student is not permitted to reenter practice or competition on the same day as the removal.**

I, _____, M.D., D.O. or _____ (other qualified licensed medical provider) have examined the following
(Print name of MD, DO or Other)
student, _____ from _____ High School/7-8th grade school
(Name of Student),
who was removed from a _____ (sport) contest at the _____ level (V, JV, 9th, 7-8th) due to exhibition of signs/symptoms/behaviors consistent with a
concussion. I have examined this student, and determined that the student is cleared to resume participation upon the completion of the directions provided below.

PLEASE INDICATE YOUR DIRECTIONS BELOW

- ___ Return to play protocol for concussion as outlined in Zurich Consensus Statement 2012 or as attached.
- ___ Return to play protocol for concussion required under direction of Licensed Athletic Trainer or other qualified Licensed medical provider as approved in above directive
- ___ Return to play protocol for concussion not required, and the student may return to participation in practice and competition on this date _____
- ___ Return to play clearance is limited to the following sport(s): _____
- ___ Other: (explain): _____

VALID ONLY WITH ALL INFORMATION COMPLETED

Signature of Medical Professional _____
(MD, DO or other qualified Licensed Medical Provider as Approved in the Above Directive)

Date: _____

Contact Information: _____

(Print or Stamp) Address: _____

Phone: _____

Return to play is also subject to clarification of this document, as deemed necessary, by Licensed Athletic Trainer, other qualified Licensed medical providers authorized by Board of Education or other governing body, or school district administration. Return to play decisions are also subject to recognized principles of conditioning, skill development, mental preparedness, etc.

Parent(s)/Guardian and student are reminded that the initial signature document of awareness of signs and symptoms of concussion and need/requirement to report are still in effect. Parent(s)/Guardian and student have a responsibility to report any further signs or symptoms of a concussion or head injury to coaches, administrators and the student- athlete's doctor. Information regarding signs and symptoms are available from school district personnel or OHSAA website.

PRESENT THIS FORM TO THE SCHOOL ADMINISTRATOR

Note: The school must retain this form indefinitely as a part of the student's permanent record. Medical Providers should retain a copy for their own records.