HEALTH and WELLNESS SERVICES

# Concussion Evaluation & Release to Play Form

Student Name: _____ Date: _____

Sports Team: _____ Grade: _____ Number of Past Concussions: _____

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

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**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 healthcare provider trained in the evaluation and management of concussions and head injuries** and receives a written clearance to return to play from the health care provider who evaluated the student-athlete, and not less than twenty-four (24) hours have passed since the student-athlete was removed from play.

Health Care Provider Name: _____

License Number: _____ Licensing Board: _____

I have evaluated the above-mentioned student-athlete and the student-athlete is:

_____ **NOT** cleared to participate in any sports-related activities (including gym class) until seen for a follow-up exam.

_____ Cleared, as of today, to return to all activities, including sports, without restrictions.

_____ Cleared to return to all activities, including sports, without restrictions, on the following date – _____.

_____ Cleared to return to sports following the schedule below. If signs and symptoms of a concussion re-occur, the student must return to the previous stage and parents must contact the licensed health care provider for instructions.

*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)

*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)

*Step 4*: May return to full practice and full contact in a controlled practice setting on the following date – _____.

Step 5: May return to full gameplay on the following date* - _____

_____ Other – please list: _____.

* Please note that if signs and symptoms of a concussion occur, the student must return to the previous stage and parents must contact the licensed health care provider for instructions.

_____ _____

(Signature of Health Care Provider) (Date)