Student-Athlete _____
Date of Injury _____
Today's Date _____
Sport _____

Medical Clearance for Gradual Return to Sports Participation Following Concussion

To be completed by the Licensed Health Care Provider

The above-named student-athlete sustained a concussion. The purpose of this form is to provide initial <u>medical clearance</u> before starting the Gradual Return to Sports Participation.

Criteria for Medical Clearance for Gradual Return to Play (check each)

The student-athlete must meet all these criteria to receive medical clearance.

- ☐ 1. No symptoms at rest/ no medication use to manage symptoms (e.g., headaches)
- ☐ 2. No return of symptoms with typical physical and cognitive activities of daily living
- ☐ 3. Neurocognitive functioning at typical baseline
- ☐ 4. Normal balance and coordination
- ☐ 5. No other medical/ neurological complaints/ findings

Detailed Guidance

<u>1. Symptom checklist:</u> None of these symptoms should be present. Assessment of symptoms should be broader than athlete report alone. Also consider observational reports from parents, teachers, others.

Physical		Cognitive	Emotional	Sleep
Headache	Visual Problems	Feeling mentally foggy	Irritability	Drowsiness
Nausea/Vomiting	Fatigue/ Feeling tired	Feeling slowed down	Sadness	Sleeping less than usual
Dizziness	Sensitivity to light/ noise	Difficulty remembering	More emotional	Sleeping more than usual
Balance Problems	Numbness/Tingling	Difficulty concentrating	Nervousness	Trouble falling asleep

<u>2. Exertional Assessment (Check):</u> The student-athlete exhibits no evidence of return of symptoms with:
__ Cognitive activity: concentration on school tasks, home activities (e.g., TV, computer, pleasure reading)
__ Physical activity: walking, climbing stairs, activities of daily living, endurance across the day
<u>3. Neurocognitive Functioning (Check):</u> The student's cognitive functioning has been determined to have returned to its typical pre-injury level by one or more of the following:
__ Appropriate neurocognitive testing
__ Reports of appropriate school performance/ home functioning (concentration, memory, speed) in the absence of symptoms listed above
<u>4. Balance & Coordination Assessment (Check):</u> Student-athlete is able to successfully perform:
__ Romberg Test OR SCAT2 (Double leg, single leg, tandem stance, 20 secs, no deviations from proper stance)
__ 5 successive Finger-to-Nose repetitions < 4 sec

I certify that: I am a Licensed Health Care Provider with training in concussion evaluation and management in accordance with current medical evidence (2010 AAP Sport-Related Concussion in Children and Adolescents, 2008 Zurich Concussion in Sport Group Consensus). The above-named student-athlete has met all the above criteria for medical clearance for his/her recent concussion, and as of this date is ready to return to a progressive Gradual Return to Sports Participation program (typically lasting minimum of 5 days).

Provider Name _____

Signature _____ **Date:** _____