Post Concussion Instructions and Return to Play Clearance Form

To: Parent/Guardian:

From: _____, at _____ School
*Name of School Representative** *Name of School*

_____, _____
*Position of School Representative** *Phone Number of School Representative**

Your child/ward may have sustained a concussion, and by policy has been removed from play until he/she has been medically cleared to return to play by a qualified health care professional.

It is not within our purview to dictate how or by whom your child/ward should be managed medically. The following serve as general guidelines only for immediate management during the first 24 hours:

1. **Diet** – drink only clear liquids for the first 8-12 hours and eat reduced amounts of foods thereafter for the remainder of the first 24 hours.
2. **Pain Medication** – do not take any pain medication except Tylenol. Dosing instructions provided with pain medications should be followed.
3. **Activity** – activity should be limited for the first 24 hours, this would involve no school, video games, extracurricular or physical activities or work when applicable.
4. **Observation** – several times during the first 24 hours:
    a. Check to see that the pupils are equal. Both pupils may be large or small, but the right should be the same size as the left.
    b. Check the athlete to be sure that he/she is easily aroused; that is, responds to shaking or being spoken to, and when awakened, reacts normally.
    c. Check for and be aware of any significant changes. (See #5 below)
5. **Significant changes -** Conditions may change significantly within the next 24 hours. **Immediately obtain emergency care for any of the following signs or symptoms:**
    a. Persistent or projectile vomiting
    b. Unequal pupil size (see 4a above)
    c. Difficulty in being aroused
    d. Clear or bloody drainage from the ear or nose
    e. Worsening headache
    f. Seizures
    g. Slurred speech
    h. Can't recognize people or places – increasing confusion
    i. Weakness or numbness in the arms or legs
    j. Unusual behavior change – increasing irritability
    k. Loss of consciousness
6. **Improvement**
    a. The best indication that an individual who has suffered a significant head injury is progressing satisfactorily, is that he/she is alert and behaving normally.
7. **Contact your health care provider**
    a. Before returning to physical activities, contact your health care provider for evaluation. If he or she diagnoses a concussion, use the attached form to help your health care provider determine when your child/ward is fully recovered and able to resume normal activities, including sports.
    b. Talk to your health care provider about the following:
        i. Management of symptoms
        ii. Appropriate levels of school activity or the need for reducing academic coursework for a temporary period of time
        iii. Appropriate levels of physical activity
8. **Return clearance form prior to returning your child to play**
    a. Before your child will be allowed to return to play, you will need to return:
        i. "Concussion Return to Play Clearance Form" signed by your care provider to the school.
        ii. "Parent/Guardian Concussion Return to Play Clearance Form"

Medical Clearance
To Begin Return to Play Protocol

_____
School

_____ _____
Student/Athlete Name *Date of Birth*

_____ _____
Date of Injury *Date of Initial Exam*

☐ After reviewing the available medical facts, it is my opinion the above named athlete did NOT sustain a concussion on the date of injury noted and is medically released to return to play in the above sport.

☐ The above named athlete did sustain a concussion on the date of injury noted, **has recovered but has not progressed through the return to play protocol.** The athlete is therefore medically released to continue to advance activities per the graduated return to play protocol (see table on page 3). Ideally, the student athlete's progress through the stages will be monitored by a licensed athletic trainer. When a licensed athletic trainer is not available the athlete is to be monitored in their progress through each stage by a responsible adult who at a minimum:

a. has been trained in the recognition of signs and symptoms of concussion
b. will have consistent contact with the student/athlete
c. and is familiar with the *Return to Play Protocol* and stages

_____ _____
Health Care Professional Signature *Date signed*

_____ _____
Health Care Professional Name (printed or typed) *Office phone*

By signing this form the health care professional is certifying that, per Utah code, they are a licensed health care provider practicing within their scope of practice, and have within 3 years of this date completed a continuing education course in the evaluation and management of concussion. The signature invokes the condition checked above.

Concussion Return to Play Clearance Form

- There may be circumstances, based on an individual's concussion severity, where the return to play protocol may take longer. Under all circumstances the progression through this protocol shall be overseen by the managing health care professional.
- Each athlete with a concussion shall be personally evaluated by an appropriate health care professional at least one time during this process.
- When the athlete has successfully passed through stage 5 (Full Contact Practice) and has previously been evaluated by an appropriate health care professional or recognized concussion management program, a clearance may be obtained from the individual designated on this form if authorized by the managing health care professional.
- A completed *Concussion Return to Play Clearance Form* indicating the student is medically released to return to full competition shall be provided to school officials prior to a student who has been removed from a contest or practice for a suspected concussion, being allowed to return to play.

GRADUATED RETURN TO PLAY PROTOCOL		
Stage	Functional Exercise or Activity	Objective
1. No structured physical or cognitive activity. Cleared to return to school full time.	Only Basic Activities of Daily Living (ADLs). When indicated, complete cognitive rest followed by gradual reintroduction of schoolwork.	**Rest and recovery, avoidance of overexertion.** Date Cleared:_____Initial_____
2. Light Aerobic Physical Activity	Non-impact aerobic activity (e.g. swimming, stationary biking) at <70% estimated maximum heart rate for up to 30 minutes as symptoms allow.	**Increase heart rate, maintain condition, assess tolerance of activity.** Date Cleared:_____Initial_____
3. Moderate aerobic physical activity and Non-contact training drills at half speed	Non-contact sport specific drills at reduced speed; Aerobic activity at 70-85% estimated maximum heart rate; light resistance training (e.g. weights at <50% previous max ability)	Begin assimilation into team dynamics, introduce more motion and non-impact jarring. Date Cleared:_____Initial_____
4. Non-contact training drills at full Speed	Regular Non-contact training drills; aerobic activity at maximum capacity including sprints; regular weight lifting routine	Ensure tolerance of all regular activities short of physical contact. Date Cleared:_____Initial_____
5. Full Contact Practice	Full Contact Practice	Assess functional skills by coaching staff, ensure tolerance of contact activities. Date Cleared:_____Initial_____
6. Return to Play	**Regular game competition**	

_____ _____ _____

Person responsible for monitoring progress *Signature* *Date*

The individual responsible for monitoring the progress of the student-athlete through the stages of the *Return to Play Protocol* should consult with the managing health care professional when necessary.

Concussion Return to Play
Medical Clearance

_____
School

_____ _____ _____
Student/Athlete Name *Date of Birth*

_____ _____
Date of Injury *Date of Initial Exam*

MEDICAL CLEARANCE

I certify that the above named athlete is medically released to return to play and fully participate in competition.

_____ _____
Health Care Professional Signature *Date signed*

_____ _____
Health Care Professional Name (printed or typed) *Office phone*

By signing this form the health care professional is certifying that, per Utah code, they are a licensed health care provider practicing within their scope of practice, and have within 3 years of this date completed a continuing education course in the evaluation and management of concussion.

PARENTAL/GUARDIAN CLEARANCE

I certify that the above named student has my permission as his/her parent/guardian to return to competition at the above named school and has completed the graduated return to play protocol process symptom free for concussions.

_____ _____
Parent/Guardian Signature *Date signed*

_____ _____
Parent/Guardian Name (printed or typed) *Phone*

To: Health Care Provider

This form has been developed in order to provide a uniform method for health care professionals to provide a written release for student/athletes to return to play after having suffered a concussion or having demonstrated signs, symptoms or behaviors consistent with a concussion and having been removed from competition or practice as a result.

As of May 2011, Utah State Law requires that a child suspected of having sustained a concussion be removed from sporting events and prohibited from returning to play until that child has been evaluated by an appropriate health care provider.

The law requires the following of the health care provider:

- Provide the amateur sports organization with a written statement, stating that within 3 years before the day on which the written statement is made that they have successfully completed a continuing education course in the evaluation and management of concussion.
- Provide the amateur sports organization written clearance that the child is cleared to resume participation in the sporting event of the amateur sports organization

While this form does not presume to dictate to professionals how to practice medicine, the guidelines for return to play from a concussion do represent consensus expert opinion from national and world leaders in sport concussion management.[1,2] The components of this form are intended to address concerns of coaches, parents, student/athletes, administrators, and healthcare professionals regarding written clearance from a health care professional for a concussed student/athlete to return to play.

In order to maintain compliance with the law, our organization requests that the healthcare provider utilize this form in granting medical clearance to return to sporting events.

SUGGESTED PRINCIPLES IN CLEARING A STUDENT/ATHLETE TO RETURN TO PLAY

- *Recovery from concussion and progression through the Return-to-Play stages is individualized and determined on a case by case basis.* Many factors influence the rate of progression and include previous concussion history, duration and types of symptoms, age and sport/activity in which the student/athlete participates. Student/athletes with a history of prior concussion, extended duration of symptoms, or participation in collision or contact sports may progress more slowly.
- The following table is adapted from the 3rd International Conference on Concussion in Sport[1] and provides the framework for the return to play protocol.
- It is expected that student/athletes will start in stage 1 and remain in stage 1 until symptom free.
- The patient may, under the direction of a health care professional, progress to the next stage only when the assessment battery has normalized. The assessment battery may include any or all of the following:
    - Symptom assessment
    - Cognitive assessment with computerized or other appropriate neuropsychological assessment
    - Balance assessment along with general neurologic examination.
- It is anticipated that at least 24 hours will be required, at a minimum, of being asymptomatic with each stage before progressing to the next stage.

Utilizing this framework, in a **best case scenario**, a patient sustaining a concussion and being asymptomatic by the next day will start in Rehabilitation Stage 1 at post injury day 1 and progress through to stage 6, 'Return to Play' by post injury day 6.

POST-CONCUSSION SYMPTOM SCALE

Name:_____ Date:_____

Instructions: For each item indicate how much the symptom has bothered you over the ***past 2 days.***

	Symptoms	None	Mild		Moderate		Severe	
Physical	**Headache**	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Nausea	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Vomiting	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Balance Problems	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Dizziness	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Visual Problems	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Fatigue	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Sensitivity to Light	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Sensitivity to Noise	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Numbness/Tingling	**0**	**1**	**2**	**3**	**4**	**5**	**6**
Thinking	**Feeling Mentally Foggy**	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Feeling Slowed Down	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Difficulty Concentrating	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Difficulty Remembering	**0**	**1**	**2**	**3**	**4**	**5**	**6**
Sleep	**Drowsiness**	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Sleeping Less than Usual	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Sleeping More than Usual	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Trouble Falling Asleep	**0**	**1**	**2**	**3**	**4**	**5**	**6**
Emotional	**Irritability**	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Sadness	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Nervousness	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Feeling more Emotional	**0**	**1**	**2**	**3**	**4**	**5**	**6**
Pain other than Headache		**0**	**1**	**2**	**3**	**4**	**5**	**6**

Exertion: Do these symptoms worsen with:

Physical Activity	☐	**Yes**	☐	**No**	☐	**Not Applicable**
Thinking/Cognitive Activity	☐	**Yes**	☐	**No**	☐	**Not Applicable**

Over the past two days, my daily activity level has been _____% of normal.