Florida High School Athletic Association

Created 06/12

Post Head Injury/Concussion Initial Return to Participation

(Page 1 of 2)

This completed form must be kept on file at the student-athlete's school.

Student Name: _____ School: _____ DOB: _____/_____/_____

Sport: _____ Date of Injury: _____/_____/_____

I certify that the above listed student-athlete has been evaluated for a concussive head injury, is currently asymptomatic with a normal neurological examination, off of all medications related to this concussive injury and (as available) all computerized neurological tests have returned to baseline (Zurich Stage 1). **The student-athlete named above is cleared to begin a graded return to play protocol (outline below) under the supervision of an athletic trainer, coach or other health care professional as of the date indicated below.**

Date Cleared for Graded Return to Play Protocol: _____/_____/_____

If the student-athlete experiences a return of any of his/her concussion symptoms while attempting a graded return to play, the student-athlete is instructed to stop play immediately and notify a parent, licensed athletic trainer or coach.

Physician Name: _____ Signature/Degree: _____

Phone: (_____) _____ Fax: (_____) _____ Date: _____/_____/_____

Graded Return to Play Protocol

Each step should take at least 24 hours to complete. If the athlete experiences a return of any concussion symptoms they must immediately stop activity, wait at least 24 hours or until asymptomatic, and drop back to the previous asymptomatic level. This protocol **must be performed under supervision.** Please initial and date the box next to each completed step.

Once the athlete has completed full practice (i.e. stage 4), please sign and date below and return this form to the student-athlete's physician (MD/DO) for review and request the physician complete the return to competition form for the athlete to resume full activity.

Rehabilitation stage	Functional exercise at each stage	Objective	Date completed	Initials
1. Light aerobic exercise	Walking, swimming, stationary bike, HR<70% maximum	Increased heart rate		
2. Sport-specific exercise	Non-contact drills	Add movement		
3. Non-contact training	Complex (non-contact) drills/ practice	Exercise, coordination and cognitive load		
4. Full contact practice	Full contact practice	Restore confidence and simulate game situations		

I attest the above-named student-athlete has completed the graded return to play protocol as dated above.

Athletic Trainer/Coach Name: _____ Signature: _____ Date: _____/_____/_____

(if athletic trainer) AT License Number: _____ Phone: (_____) _____

(if coach) AD/Principal Name: _____ School: _____ Phone: (_____) _____

Student-Athlete Signature: _____ Date: _____/_____/_____

Physician Reviewed:

_____

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Return to Competition Affidavit

Student-Athlete's Name: _____

Date of Birth: _____/_____/_____ Injury Date: _____/_____/_____

Formal Diagnosis: _____

School: _____

Sport: _____

I certify that I have reviewed the signed graded return to activity protocol provided to me on behalf of the athlete named above. This athlete is cleared for a complete return to **full-contact physical activity** as of _____/_____/_____.

This student-athlete is instructed to stop play immediately and notify a parent, licensed athletic trainer or coach and to refrain from activity should his/her symptoms return.

Physician Name: _____

Physician Signature:_____ License No.: _____

Phone: (_____) _____ Fax: (_____) _____ E-mail: _____

Date: _____/_____/_____