Medical Clearance for Gradual Return to Sports Participation Following Concussion

To be completed by the Authorized Health Care Provider (AHCP) (Physician, Neuropsychologist, Nurse Practitioner, Physician’s Assistant)

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

Criteria for Medical Clearance for Gradual Return to Play as cited by 2010 AAP Sport-Related Concussion in Children and Adolescents, 2008 Zurich Concussion in Sport Group Consensus. (Check each)

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

☐ 1. No symptoms at rest
☐ 2. No return of symptoms with typical and cognitive activities of daily living
☐ 3. Neurocognitive functioning at typical pre-injury level
☐ 4. Normal balance and coordination
☐ 5. No other medical/neurological complaints/findings

Detailed Guidance

1. **Symptom Checklist:** 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.

<table>
<thead>
<tr>
<th>Physical</th>
<th>Cognitive</th>
<th>Emotional</th>
<th>Sleep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headaches</td>
<td>Sensitivity to light</td>
<td>Feeling mentally foggy</td>
<td>Irritability</td>
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<tr>
<td>Nausea</td>
<td>Sensitivity to noise</td>
<td>Problems concentrating</td>
<td>Sadness</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Numbness/tingling</td>
<td>Problems remembering</td>
<td>More emotional</td>
</tr>
<tr>
<td>Visual Problems</td>
<td>Vomiting</td>
<td>Feeling slowed down</td>
<td>Nervousness</td>
</tr>
<tr>
<td>Balance Problems</td>
<td>Dizziness</td>
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</tbody>
</table>

2. **Exertional Assessment (Check):** 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

3. **Neurocognitive Functioning (Check):** 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

4. **Balance & Coordination Assessment (Check):** Student-athlete is able to successfully perform (SCAT2):
   - __Double leg, single leg, tandem stance (20 seconds, no deviations from proper stance)
   - __5 successive Finger-to-Nose repetitions < 4 sec

I certify that: I am aware of the current medical guidance on concussion evaluation and management; 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 (lasting minimum of 5 days).

AHCP Name ____________________________ Date ____________

Distribution: White–Parent; Yellow–Athletic Trainer; Pink–School Health Room; Goldenrod–AD

RETURN FORM TO SCHOOL NURSE