Concussion Return to Play Clearance Form

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

Date	*Date of Injury*	*Date of Initial Exam*

The athlete identified above sustained a concussion on the aforementioned date. He/she has fully returned to the classroom, is symptom free at rest and has reached his/her baseline on the ImPACT test. Please indicate your release to complete the "Return to Play" protocol as outlined below:

Day 1 – Light Aerobic Exercise
Day 2 – Sport-Specific Exercise
Day 3 – Non-contact Drills
Day 4 – Full-contact Drills
Day 5 – Game Play

_____ _____
Health Care Professional Signature ***Date***

As parent/guardian of the aforementioned athlete, I hereby consent to have my child complete the "Return to Play" protocol - *understanding the risks associated with a concussion* - and thereby give my full support to the Health Care Professional and the concussion management team, trusting their judgment to allow my son/daughter to return to play. I hereby give permission for my son/daughter to resume participation in their sport/activity.

_____ _____
Parent/Guardian Signature ***Date***

A member of the CMT will monitor the student-athlete's progress through the "Return to Play" protocol. The CMT will consult parents and the stuent-athlete's health care professional whenever necessary or if there is a change in the athletes condition during the "Return to Play" protocol. I certify that the aforementioned athlete has successfully completed the "Return to Play" protocol.

_____ _____
Member of Concussion Management Team Signature ***Date***