CONCUSSION – RETURN TO PARTICIPATION MEDICAL RELEASE

The following athlete has been evaluated and diagnosed with a concussion by a licensed health care professional trained in the evaluation of concussions. The following steps must be completed under the supervision of a medical professional *(MD, DO, PA, Advanced Practice Nurse, AT)* who **IS TRAINED IN THE EVALUATION AND MANAGEMENT OF CONCUSSIONS (as outlined in Idaho Code 33-1625).** This form must be signed by the above referenced medical professional and returned to the league, organization, or athletic trainer in order for the athlete to return to participation.

In accordance with the Centers for Disease Control and Prevention *(CDC)*, **the RETURN-TO-PLAY Protocol begins with RETURN-TO-LEARN** *(successfully tolerating school and resumption of a full cognitive workload)* and there is a six *(6)* step process gradually returning the athlete to normal activities. There is a minimum of a 24-hour period between each step. If at any time the athlete's concussion symptoms reoccur they must return to the previous asymptomatic level and reattempt progression after a further 24-hour period of rest has passed.

Graduated Return-To-Play *(RTP)*:

Stage 1 – Rest until asymptomatic *(physical and cognitive rest)*
Stage 2 – Light aerobic activity *(light jogging, stationary bike or treadmill)*
Stage 3 – Moderate exercise *(moderate jogging, brief running, or stationary biking)*
Stage 4 – Non-Contact Sports Specific Drills and Light Weight Training
Stage 5 – Full Contact Drills and Training with **MEDICAL CLEARANCE**
Stage 6 – Return to competition *(No Restrictions)*

Athlete Name:_____ **DOB:**____/____/_____

Injury Date: ____/____/_____ **Sport:**_____ **Level:** *(Varsity, JV, Club, etc.)* _____

Mechanism of Injury:

Symptoms upon Evaluation:

Sideline Evaluation Completed: Yes ☐ No ☐ **Completed by:** _____

I *(treating MD/DO/PA/Advanced Practice Nurse/AT*) certify that the aforementioned athlete has completed the above Return-to-Play Protocol and is cleared for full athletic participation, and, **IF ASYMPTOMATIC**, may return to competition.

Name:_____ **Signature:**_____

Phone:_____ **Fax:**_____ **Today's Date:** _____

I (parent/guardian) attest that my child has successfully completed the full Return-to-Play Protocol as outlined above, and has been cleared to return to participation by a medical professional trained in concussion management. I understand that sports are inherently dangerous and realize that concussions are an injury that can occur. I also understand that this process/protocol is in place to protect my child, that any deviation from this process/protocol in under violation, and I take full responsibility for any and all consequence of that decision.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Phone:_____ **Today's Date:** _____