Athlete Name: _____

Date of Injury: _____

Concussion Follow-Up Evaluation

This form is to be completed by a medical professional (MD, DO, NP, or PA) trained in the evaluation and management of concussions.

Injury Status

- ☐ Has been diagnosed by a MD/DO with a concussion.
- ☐ Was evaluated by a MD/DO and did not have a concussion injury. There are no limitations on school and physical activity.

Academic Participation

Please provide recommendation(s) for the athlete regarding their return to academic participation. ***Mark all that apply:***

- ☐ 1. This student is not to return to school **(Follow up required).**
- ☐ 2. This student may begin to return to school based on graduated progression through the ***CIF Concussion Return to Learn Protocol.***
- ☐ 3. This student requires the necessary school accommodations set forth by the "***Physician (MD/DO) Recommended School Accommodations Following Concussion"*** form (next page).
- ☐ 4. This student may be released to full academic participation.

Comments:_____

Sports Participation

Please provide recommendation(s) for the athlete regarding their return to athletic/sport participation. ***Mark all that apply:***

- ☐ 1. This student is not to participate in physical activity of any kind **(Follow up required).**
- ☐ 2. This student is not to participate in recess or other physical activities except for untimed, voluntary walking **(Follow up required).**
- ☐ 3. This student may begin and complete a gradual return to play progression under the supervision of the athletic trainer for CCA. May return to competition upon successful completion of return to play. (**No follow up required).**
- ☐ 4. This student may begin a gradual return to play progression under the supervision of the athletic trainer for CCA. This student **must return to the physician for final clearance before returning to competition (Follow up required).**
- ☐ 5. This student has medical clearance for unrestricted athletic participation. **(Has completed the CIF Concussion RTP Protocol).**

Comments:_____

Medical Office Information:

Date of Evaluation: _____ Follow-up Date (If Requested): _____

Physician Stamp: Physician Signature: _____

Please return to Athletic Trainer: Lauren Smart, MS, ATC, CES