RETURN TO PLAY AFTER CONCUSSION FORM

Organization: _____ Athlete's Name: _____

Athlete's D.O.B._____Athlete's Parent/Guardian_____

Injury Date/Time: _____Sport/Activity: _____

Concussion Team Leader: _____ Athlete's PCP: _____

Date of start of Graduated Exercise: _____ Symptom score then:_____

Symptom score now:_____Date of symptom score now:_____

Date of baseline ImPACT Test: _____Was baseline ImPACT test valid? Yes No

Date of Post-injury ImPACT Test:_____Post-injury ImPACT normalized? Yes No

Date of Post-injury ImPACT Test interpretation: _____

Name of Post-injury Impact Test interpreter: _____

The athlete named above is has gone through the concussion management protocol at his or her school and has met the following three criteria:

1. **The athlete reports no significant post concussive symptoms at rest.**
2. **The athlete reports no significant post concussive symptoms with exertion.**
3. **The athlete has returned to baseline or normative values on his or her ImPACT testing.**

The athlete and his or her parents/guardians understand that if the athlete is not truthful and denies any symptoms or attempts to not fully cooperate with ImPACT testing, the athlete could be putting his or her life and health at risk.

This athlete may return to full contact sports participation as of (date): _____

Name of Qualified Medical Provider (please print): _____

Signature of Qualified Medical Provider: _____

Title of Qualified Medical Provider (please circle one): M.D. D.O. P.A. N.P.

Phone number of Qualified Medical Provider: _____

Date of evaluation: _____

SEVERITY RATING

Please use this scale to rate each symptom.

None	Mild		Moderate		Severe	
0	1	2	3	4	5	6

PATIENT'S NAME:_____

POST-CONCUSSION SYMPTOM SCALE

Symptoms	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Headache							
Nausea							
Vomiting							
Balance Problems							
Dizziness (spinning or movement sensation)							
Lightheadedness							
Fatigue							
Trouble falling asleep							
Sleeping more than usual							
Sleeping less than usual							
Drowsiness							
Sensitivity to light							
Sensitivity to noise							
Irritability							
Sadness							
Nervous/Anxious							
Feeling more emotional							
Numbness or tingling							
Feeling slowed down							
Feeling like "in a fog"							
Difficulty concentrating							
Difficulty remembering							
Visual problems							
Other							
Total							