

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:
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						