Florida High School Athletic Association

Revised 04/18

Post Head Injury/Concussion Initial Return to Participation

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This form is to be completed by an appropriate health care provider (AHCP-MD/DO) trained in the latest concussion evaluation and management protocols as defined in FHSAA policy 40.2 for any student-athlete that has sustained a concussion and must be kept on file at the student-athlete's school. The choice of AHCP remains the decision of the parent/guardian or responsible party of the student-athlete.

Athlete Name: _____ DOB: _____/_____/_____ Injury Date: _____/_____/_____

Sport: _____ School: _____ Level (Varsity. JV, etc.): _____

I (treating physician) certify that the above listed athlete has been evaluated for a concussive head injury, and currently is/has:
(All Boxes MUST be checked before proceeding)

- ☐ Asymptomatic
- ☐ Normal neurological exam
- ☐ Off medications related to this concussion
- ☐ Returned to normal classroom activity
- ☐ Yes ***or*** ☐ N/A Neuropsychological testing (as available) has returned to baseline

The athlete named above is cleared to begin a graded return to play protocol (outline below) under the supervision of an athletic trainer, coach or other health care professional as of the date indicated below. If the athlete experiences a return of any of his/her concussion symptoms while attempting a graded return to play, the athlete is instructed to stop play immediately and notify a parent, licensed athletic trainer or coach.

By signing below, I certify that I am a medical doctor (MD/DO) familiar with the most current 2016 Consensus Statement on Concussion in Sport and the tools used for evaluation (ex. SCAT5). This information will be used to guide return to play progression (page 1) and final clearance to return to competition.

Physician Name: _____ Signature/Degree: _____MD/DO

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

Graded Return to Play Protocol

After a brief period of initial rest (24-48 hr), symptom-limited activity can begin while staying below a cognitive and physical exacerbation threshold.

Once concussion-related symptoms have resolved, the athlete should continue to proceed to the next level if he/she meets all criteria without recurrnce of symptoms. Generally each step should take at least 24 hrs, however, this time frame may vary with player age, history, level of sport, etc., and management must be individualized.

Rehabilitation stage	Functional exercise at each stage	Objective	Date completed	Initials
1. Symptom limited activity	Daily activities that do not provoke symptoms	Gradual reintroduction of work/school activities	Noted above	Signed above
2. Light aerobic exercise	Walking, swimming, stationary bike, HR<70% maximum; no weight training	Increased heart rate		
3. Sport-specific exercise	Non-contact drills, running drills: no impact	Add movement		
4. Non-contact training	Complex (non-contact) drills/practice	Exercise, coordination and cognitive load		
5. Full contact practice	Full contact practice, normal activities	Restore confidence and simulate game situations		
6. Return to full activity	Return to competition	**After completion of the steps above; Form AT18, Page 2 must be completed by physician**		

I attest the above named athlete has completed the graded return to play protocol as dated above.

Athletic Trainer / Coach Name: _____ AT License Number: _____ Phone: _____

Athletic Trainer / Coach Signature: _____ Date: _____/_____/_____

Physician Reviewed:

_____

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Return to Competition Affidavit

Student-Athlete's Name: _____

Date of Birth: _____/_____/_____ Injury Date: _____/_____/_____

Formal Diagnosis: _____

School: _____

Sport: _____

I certify that I have reviewed the signed graded return to activity protocol provided to me on behalf of the athlete named above. This athlete is cleared for a complete return to **full-contact physical activity** as of _____/_____/_____.

This student-athlete is instructed to stop play immediately and notify a parent, licensed athletic trainer or coach and to refrain from activity should his/her symptoms return.

Physician Name: _____

Physician Signature:_____MD/DO License No.: _____

Phone: (_____) _____ Fax: (_____) _____ E-mail: _____

Date: _____/_____/_____

By signing above, I certify that I am a medical doctor (MD/DO) familiar with the most current 2016 Consensus Statement on Concussion in Sport and the tools used for evaluation (ex: SCAT5). This information will be used to guide return to play progression (page 1) and final clearance to return to competition.