**Bothell High School**

**Concussion Return-to-Play Form**

**On site evaluation by:(name/position) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Incident\_\_\_\_\_\_\_**

Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Graduation YEAR**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sport/Event? \_\_\_\_\_\_\_\_\_\_\_\_\_\_How did injury occur:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms:**

 Headache Neck Pain Nausea/vomiting

 Dizziness Vision Problems Drowsiness

 Confusion Sensitivity to Light/Noise Foggy/Sluggish/Fatigue

 Personality Changes Concentration/Memory Problems Balance Problems

 Pressure in Head Recall Problems prior/post event \_\_\_\_\_\_ Numbness/Tingling

 Other:

**Assessments Performed:**

 Orientation Immediate Memory Delayed Memory

 Concentration Coordination Balance

 PEARL Cranial Nerve Assessment **\_\_\_\_\_\_** Base line impact test exp date\_\_\_\_

**Dr. completion REQUIRED**

 **Please FILL IN appropriate section I – IV below.**

***Please take this form to your doctor’s appointment to be filled out. This form must be completed and returned to the Athletic Trainer or faxed to (425)408-7002 before the athlete can start the return-to-play protocol. This form is not for general injury clearance-- use the “Athletic Injury Return-to-Play” form.***

**Date of doctor visit: . S**ymptoms at time of visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I**. **NO concussion diagnosed.** Patient allowed to return to **full activity** as of \_\_\_\_\_\_\_\_\_(date).

**II.** Patient is **ready** to start the monitored return-to-play protocol as of \_\_\_\_\_\_\_\_\_(date) beginning **at step** \_\_\_\_\_ ( please specify from below):

 Each step is separated by 24 hours; back up one day if any symptoms return.

1. No activity and rest until asymptomatic 2. Light aerobic exercise

3. Sport-specific exercise 4. Noncontact drills

5. Full-contact drills 6. Game play

**III.** Patient is **not cleared** to start monitored return-to-play protocol and will be seen by treating doctor again on (date).

**IV.** Patient is being **referred** for further testing/evaluation to:

Physician’s Signature: Date:

Physician’s Name: please print Phone:

Athletic Trainer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(signed upon return of form) Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there is other supporting documentation it is attached:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(trainer initial)