RETURN TO PLAY CHECKLIST

Coach____________________  Sport ______________  Level ___________

*Coaches please fill out completely and return to the nurse prior to returning an athlete to competition.

Name of Athlete ______________________________
Date you began return to play protocol __________
Date you completed the return to play protocol ________

Day 1: Light aerobic activity

Name of activity performed _______________  symptoms yes or no

- If yes please describe symptoms__________________________________________

Date _________  Date completed without symptoms ________

Day 2: Sport-specific activity

Name of activity performed _______________  symptoms yes or no

- If yes please describe symptoms__________________________________________

Date _________  Date completed without symptoms ________

Day 3: Non-contact training drills

Name of activity performed _______________  symptoms yes or no

- If yes please describe symptoms__________________________________________

Date _________  Date completed without symptoms ________

Day 4: Full contact practice

Name of activity performed _______________  symptoms yes or no

- If yes please describe symptoms__________________________________________

Date _________  Date completed without symptoms ________

Day 5: Return to play date _________

Athletic Director ___________________________

School Nurse ___________________________