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 _____