Concussion Return to Play Clearance Form

Student/Athlete Name ***Date of Birth*** ***School Name***

Today's Date ***Date of Injury*** ***Date of Initial Exam***

The athlete identified above sustained a concussion on the aforementioned date. He/She has fully returned to the classroom, is symptom free at rest and has reached his/her baseline on the Sway Medical test. Please indicate your release to complete the "Return to Play" protocol as outlined below

Day 1 - Light Aerobic Exercise
Day 2 - Sport-Specific Exercise
Day 3 - Non-Contact Drills
Day 4 - Full-Contact Drills
Day 5 - Game Play

Health Care Professional Signature **Date**

As parent/guardian of the aforementioned athlete, I hereby consent to have my child complete the "Return to Play" protocol - *understanding the risks associated with a concussion* - and thereby give my full support to the Health Care Professional and the concussion management team, trusting their judgment to allow my son/daughter to return to play. I hereby give permission for my son/daughter to resume participation in their sport/activity.

Parent/Guardian Signature ***Date***

A member of the CMT will monitor the student-athlete's progress through the "Return to Play" protocol. The CMT will consult parents and the student-athlete's health care professional whenever necessary or if there is a change in the athlete's condition during the "Return to Play" protocol. I certify that the aforementioned athlete has successfully completed the "Return to Play" protocol.

Member of Concussion Management Team Signature ***Date***