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PROVIDENCE
Children's Health

Concussion: Graded "Return-to-Participation" Documentation

To be completed by athlete's parent/guardian

Athlete's name: _____ **Date of birth:** _____ /_____ /_____ **Age/grade:** ____/_____

Date of injury: _____ **Documentation completed by:** _____

Symptoms	Activity preceding symptom	Graded Symptoms Checklist									
		Date/Time:	Date/Time:	Date/Time:	Date/Time:	Date/Time:	Date/Time:	Date/Time:	Date/Time:	Date/Time:	Date/Time:
	Headache										
	Pressure in head										
	Neck pain										
	Nausea or vomiting										
	Dizziness										
	Blurred vision										
	Balance problems										
	Sensitivity to light										
	Sensitivity to noise										
	Feel slowed down										
	Feel like "in a fog"										
	Don't feel "right"										
	▼ concentration										
	▼ memory										
	Fatigue/low energy										
	Confusion										
	Drowsiness										
	Difficulty sleeping										
	More emotional										
	Irritability										
	Sadness										
	Nervous/anxious										

Comments:

Information provided by Providence Sports Care Center:

Oregon YOUTH SOCCER

Concussion: Return-to-Participation Medical Release

To be completed by a physician

Athlete's name: _____

Date of birth: _____/_____/_____ **Age/grade:** ____/_____ **Date of injury:**_____

Dear Physician,

This athlete was evaluated and determined to have sustained a concussion on _____. Since that time, the athlete has been monitored for symptoms during academic and sports activities (see reverse side). Please evaluate the athlete and provide appropriate recommendations to be followed by athlete, coaches, teachers, parents, etc. Thank you for your time and assistance.

Additional information can be found at: www.cdc.gov/concussion/HeadsUp/physicians_tool_kit.html

Return to sports participation is allowed only after following these graduated steps:

1. **No activity:** Complete rest, both physical and cognitive. This may include staying home from school or limiting school hours and/or homework since activities requiring concentration and attention may worsen symptoms and delay recovery.
2. **Light aerobic exercise:** Low-intensity walking or stationary bike riding; no weight lifting or resistance training

Before progressing to the next stages, the student must be healthy enough to return to school full time.

3. **Sport-specific exercise:** Begin sprinting, dribbling basketball or soccer; no helmet or equipment allowed; no head-impact activities
4. **Non-contact training:** Begin more complex drills in full equipment, weight training or resistance training

Physician release is required before progressing to Steps 5 and 6.

5. **Full-contact practice:** Participate in normal training activities.
6. **Unrestricted return-to-participation and full competition** (also complete "Return to Participation" form)

The athlete should spend a minimum of one day at each step. If symptoms recur, the athlete must stop the activity.
The student must rest for a minimum of 24 hours and then resume activity one step below where he/she was when the symptoms occurred.
Graduated return applies to all activities, including academics, electronics, sports, riding bikes, PE classes, chores, playing with friends, etc.

THIS SECTION TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROFESSIONAL

- ❑ This athlete **may NOT return** to any sports activity until medically cleared.
- ❑ Athlete should **remain home from school** to rest and recover until next follow up with physician on _____ (date).
- ❑ Please **allow classroom accommodations**, such as extra time on tests, a quiet room to take tests, and a reduced workload when possible.
  Additional recommendations: _____
- ❑ Athlete **may begin graduated return at stage circled above.**

Physician/health care professional's signature: _____ **Date:** _____

Physician/health care professional's name/title (print): _____

Phone:_____