CONCUSSION EVALUATION AND RELEASE TO PLAY FORM FOR LICENSED HEALTH CARE PROVIDERS

(SECTION ONE: Completed by School Personnel)

Student Name: ___________________________________________ Date: ______________

Sport’s Team: ___________________ Grade: ________ Number of Past Concussions: ________

Brief Description by School Personnel of How Injury Occurred and Why Concussion is Suspected:
_________________________________________________________________________________

(SECTION TWO: Completed by Licensed Health Care Provider)

Per Indiana Code 20-34-7, a student athlete who is suspected of suffering a concussion may not return to play until the student athlete has been evaluated by a licensed health care provider trained in the evaluation and management of concussions and head injuries, receives a written clearance to return to play from the health care provider who evaluated the student athlete, and at least twenty-four (24) hours have passed since the student athlete was removed from play.

Health Care Provider Name: __________________________________________________________

License Number: ___________________ Licensing Board: ________________________________

I have evaluated the above mentioned student athlete and the student athlete is:

_____ NOT cleared to participate in any sports-related activities (including gym class) until seen for a follow-up exam

_____ Cleared, as of today, to return to all activities, including sports, without restrictions

_____ Cleared to return to all activities, including sports, without restrictions, on the following date* - ______________

_____ Cleared to return to sports following the schedule below:

   **Step 1:** May participate in light activity on the following date* - ______________
   (10 minutes on an exercise bike, walking, or light jogging; but no weight lifting, jumping or hard running)

   **Step 2:** May participate in moderate activity on the following date* - ______________
   (Moderate intensity activity on an exercise bike, jogging or weight lifting {reduced time and/or weight than normal})

   **Step 3:** May participate in heavy; non-contact physical activity on the following date* - ______________
   (Sprinting, running, high-intensity exercise bike, and weight lifting; but no contact sports)

   **Step 4:** May return to practice and full contact in a controlled practice setting on the following date* - ______________

   **Step 5:** May return to full game play on the following date* - ______________

_____ Other – please list:

* Please note that if signs and symptoms of a concussion occur, the student must return to the previous stage and parents must contact the licensed health care provider for instructions.

_____________________________________________ ____________________________
(Signature of Health Care Provider) (Date)

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