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 and receives a written clearance to return to play from the health care provider who evaluated the student athlete.

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* - _______________
           (Mild 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) _______________