



**FAIRFIELD COMMUNITY SCHOOLS – CONCUSSION EVALUATION
RELEASE TO PLAY FORM FOR LICENSED HEALTH CARE PROVIDERS**



Student Name: _____ Date of Birth: _____ Grade: _____

School: _____ Number of Past Concussions: _____ Date of Initial Exam: _____

Date of Injury: _____ Athletic Trainer Name and Phone Number: _____

Brief Description of Injury:

HEALTH CARE PROVIDER SECTION

Per Indiana Code 20-34-7, a student athlete who is suspected of suffering a head 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.

_____ After reviewing the available medical facts, it is my opinion the above named athlete did NOT sustain a concussion on the date of injury noted and is medically released to play after not less than twenty-four (24) hours have passed since the athlete was removed from play.

_____ After reviewing the available medical facts, it is my opinion the above mentioned athlete did sustain a concussion and IS NOT CLEARED to participate in sports-related activities (including gym class) until seen for follow-up exam.

Signature of Health Care Provider

Date

_____ The above named athlete did sustain a concussion on the date of injury noted and has recovered but has not progressed through the return to play protocol. The athlete is therefore medically released to continue to advance activities per the schedule below. Please note that if signs and symptoms of a concussion re-occur, the student must return to the previous stage and parents must contact the licensed healthcare provider for instructions.

Signature of Health Care Provider

Date

Step 1: May participate in light activity on the following date- _____
(10 min. 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)

Step 3: May participate in heavy, non-contact, sports specific physical activity on the following date- _____
(Sprinting, running, high-intensity exercise bike, weight lifting – but no contact sport)

Step 4: May return to full practice (must include full contact) on the following date- _____

_____ Other – please list restrictions: _____

_____ The above named athlete has successfully progressed through the return to play protocol and is therefore medically released to participate in all activities, including full game play, without restriction.

Signature of Health Care Provider

Date

License Number

Licensing Board

Printed Name of Health Care Provider

Location of Clinic

Phone Number