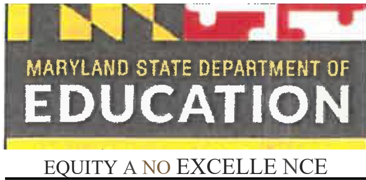

Name of Athlete:
Sport/season:
Date Received:

Medical Clearance for Student-Athlete Suspected Head Injury

Section 1: Initial Observation to be Comeleted bl£ Co ach, Athletic Trainer and/or First Res eonder

Athlete's Name: **DOB:** School: Sport:

Following the in ju[Y, did the athlete ex erience:	Circle One	S)lm12toms	Comments
Loss of consciousness or unresoonsiveness	Yes/No		
Seizure of convulsive activilv	Yes/No		
Balance problems/unsteadiness	Yes/No		
Dizziness	Yes/No		
Headache	Yes/ No		
NauseaNomiting	Yes/ No		
Emotional Instabilitv (abnormal laughing, cryina, anger)	Yes/ No		
Confusion/Easilv distracted	Yes/ No		
Sensitivitv to Li ahVnoise	Yes/ No		
Vision oroblems?	Yes/ No		
Neck pain	Yes/ No		

Describe the injury or give additional details:

Injury **History:** Name of Person Completing Form: Relationship:
Date of Injury: Time of Injury: Phone Number:

Section 2: To Be Filled Out Bl£ a Licensed Health Care Provider [LHCP)

Medical Provider Recommendations According to COMAR 13A.06.08.01, only licensed health care providers ILHCPI ***trained In the evaluation and management of concussions*** are permitted to authorize a student athlete to return to play

"This return to play (RTP) plan is based on today's evaluation

LHCP Diagnosis:

D No Concussion - May Return to Full Academic and Physical Activity

C Concussion

"PLEASE NOTE THESE REQUIREMENTS TO RETURN TO SPORTS PLEASE COMPLETE"	1. Athletes are not allowed to return to practice or play the same day that their head injury occurred **2 .** Athletes should never return to play or practice if they still have **ANY SYMPTOMS** 3. Athletes, be sure that your coach and/or athletic trainer are aware of your Injury, symptoms, and has the contact information for the treating physician
SCHOOL (ACADEMICS) **COMPLETED BY LHCP**	May return to school now U May return to school_/____ /__ Out of school until follow up (follow up is scheduled for) ¯ Limitations or Accommodations (please see below or attached)
SPORTS/PHYSICAL ACTIVITIES	May start return to play progression under the supervision of the health care provider for your school/team n Must return to medical provider for final clearance to return competition and physical activities

Additional Comments/Instructions:

Office Stamp:

LHCPName:

Signature:

Date: Phone Number:

I certify that I am aware of the current medical guidance on concussion evaluation and Management

- *All Maryland public school athletes must have a Ucensed Health Care Providers signature to return to play*
- *More than one evaluation is typically necessary for medical clearance for concussion, as symptoms may not fully present for* ***days.***

RETURN COMPLETED FORM TO SCHOOL NURSE, ATHLETIC DIRECTOR, AND ATHLETIC TRAINER