

**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 of Injury: _____

(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 not less than twenty-four (24) hours have passed since the student athlete was removed from play**. The IHSAA also states that in order to be cleared to return to play, clearance must come from a **MD or DO**.

Health Care Provider name: _____

License Number: _____ Licensing Board: _____

Medical Group Name: _____ Phone Number: _____

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

_____ **NOT Cleared** to participate in any sports-related activities (including P.E. class) until seen for a follow-up

_____ **Cleared. No concussion suspected.** May return to all activities, including sports, with no restrictions

_____ Cleared to begin post concussion return to play protocol as recommended by the IHSAA and interpreted by

Homestead below:

***24 hours must pass between each step to monitor for returning symptoms.**

Step 1: May participate in light activity on the following date* _____

(10 min. on an exercise bike, walking, or light jogging; but no weight training, 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 training [reduce 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 on the following date* _____

Step 5: May return to full game/practice with no restrictions on the following date* _____

* 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)