

Flathead Valley Little Guy Football Concussion Return to Play Form

This form is adapted from the Acute Concussion Evaluation (ACE) care plan on the CDC website (www.cdc.gov/injury). All medical providers are encouraged to review this site if they have questions regarding the latest information on the evaluation and care of the scholastic athlete following a concussion injury. Also included is a link to the SCAT 5 Sports Concussion Assessment Tool for children under 13 years of age

(<https://bjsm.bmj.com/content/bjsports/early/2017/04/26/bjsports-2017-097492childscat5.full.pdf>)

The SCAT 5 is to be utilized on players over 13 years of age

(<https://bjsm.bmj.com/content/bjsports/early/2017/04/26/bjsports-2017-097506SCAT5.full.pdf>)

Please initial any recommendations that you select below.

Athlete's Name: _____

Date of Birth: _____

Date of Injury: _____

THIS RETURN TO PLAY IS BASED ON TODAY'S EVALUATION

Date of Evaluation: _____ Care Plan Completed By: _____

Return to This Office (Date/Time): _____

Return to School On (Date): _____

RETURN TO SPORTS

PLEASE NOTE:

1. Athletes should not return to practice or play until they have had a thorough examination. If Diagnosed with Concussion beginning the SCAT 3 assessment and following the return to play guidelines over seen by an appropriate provider will begin.
2. Athletes should never return to play or practice if they still have **ANY symptoms**.
3. Athletes: Be sure that your coach, parent, league trainer or physician are aware of your injury and symptoms, and that they have the contact information for the treating

The following are the return to sports recommendations at the present time: [If allowing the athlete to return to play in any fashion, my _____ [name of health care professional] signature below represents that I have evaluated the athlete and, in my opinion, the athlete is capable of safely resuming participation in organized youth athletic activities including FVF football.

Physical Education: Do **NOT** return to PE class at this time.

May return to PE class at this time.

Sports: Do **NOT** return to sports practice or competition at this time.

May gradually return to sports practices under the supervision of the healthcare provider for your school or team.

May be advanced back to competition after phone conversation with attending physician (MD/DO/DC/PAC/LAT/ARNP/Neurophysiologist)

Must return to physician (MD/DO/DC/PAC/LAT/ARNP/Neurophysiologist) for final clearance to return to competition.

- OR -

- Cleared for full participation in all activities and restrictions. Return of symptoms should result in re-evaluation by physician (MD/DO/DC /PAC/LAT/ARNP/Neurophysiologist) for assessment.

Medical Office Information (Please Print/Stamp):

Evaluator's Name: _____ Office Phone: _____

Evaluator's Signature: _____

Evaluator's Address: _____

Return to Play (RTP) Procedures After a Concussion

1. Return to activity and play is a medical decision. The athlete must meet all of the following criteria in order to progress to activity:

Asymptomatic at rest and with exertion (including mental exertion in school) AND have written clearance from their primary care provider or concussion specialist (athlete must be cleared for progression to activity by a physician other than an Emergency Room physician, if diagnosed with a concussion).

2. Once the above criteria are met, the athlete will be progressed back to full activity following the step-wise process detailed below. (This progression must be closely supervised by a Certified Athletic Trainer. If your school does not have an athletic trainer, then the coach must have a very specific plan to follow as directed by the athlete's physician).

3. Progression is individualized, and will be determined on a case by case basis. Factors that may affect the rate of progression include: previous history of concussion, duration and type of symptoms, age of the athlete, and sport/activity in which the athlete participates. An athlete with a prior history of concussion, one who has had an extended duration of symptoms, or one who is participating in a collision or contact sport may be progressed more slowly.

4. Stepwise progression as described below:

Step 1: Complete cognitive rest. This may include staying home from school or limiting school hours (and studying) for several days. Activities requiring concentration and attention may worsen symptoms and delay recovery.

Monitor Name: _____ Date Cleared ____/____/____

Step 2: Return to school full-time.

Monitor Name: _____ Date Cleared ____/____/____

Step 3: Light exercise. This step cannot begin until the athlete is no longer having concussion symptoms and is cleared by a physician for further activity. At this point the athlete may begin walking or riding an exercise bike. No weight-lifting.

Monitor Name: _____ Date Cleared ____/____/____

Step 4: Running in the gym or on the field. No helmet or other equipment.

Monitor Name: _____ Date Cleared ____/____/____

Step 5: Non-contact training drills in full equipment. Weight-training can begin.

Monitor Name: _____ Date Cleared ____/____/____

Step 6: Full contact practice or training.

Monitor Name: _____ Date Cleared ____/____/____

Step 7: Play in game. Must be cleared by physician before returning to play.

- **For children under the age of 13 a minimum of 48-72 hours before advancing to the next.**
- **For Children above the age of 13 a minimum of 24 hours before advancing to the next step.**

If post-concussion symptoms occur at any step, the athlete must stop the activity and the treating physician must be contacted. Depending upon the specific type and severity of the symptoms, the athlete may be told to rest for 24 hours and then resume activity at a level one step below where he or she was at when the symptoms occurred.

IMPORTANT

This Form must be returned to the head coach and an FVF Board member. The head coach must also make form available to FVF Board for evaluation prior to athlete's clearance. No player shall be returned to practice until the appropriate medical provider has signed this form authorizing return to play, the parent/guardian has signed this form and FVF has approved return to play.

Parent/Legal Guardian:

I hereby acknowledge/agree that my son/daughter may return to play as indicated in this form.

Parent/Legal Guardian

Date

Print name: _____