Figure 6

MARYLAND STATE DEPARTMENT OF EDUCATION
Preparing World-Class Students

Student-Athlete_____

Date of injury _____

Today's Date _____

Sport _____

Medical Clearance for Gradual Return to Sports Participation Following Concussion

To be completed by the Licensed Health Care Provider

The above-named student-athlete sustained a concussion. The purpose of this form is to provide initial medical clearance before starting the Gradual Return to Sports Participation.

Criteria for Medical Clearance for Gradual Return to Play (Check each)

The student-athlete must meet all of these criteria to receive medical clearance.

- ☐ 1. No symptoms at rest/ no medication use to manage symptoms (e.g., headaches)
- ☐ 2. No return of symptoms with typical physical and cognitive activities of daily living
- ☐ 3. Neurocognitive functioning at typical baseline
- ☐ 4. Normal balance and coordination
- ☐ 5. No other medical/ neurological complaints/ findings

Detailed Guidance

1. Symptom checklist: None of these symptoms should be present. Assessment of symptoms should be broader than athlete report alone. Also consider observational reports from parents, teachers, others.

Physical		Cognitive	Emotional	Sleep
Headaches	Sensitivity to light	Feeling mentally foggy	Irritability	Drowsiness
Nausea	Sensitivity to noise	Problems concentrating	Sadness	Sleeping more than usual
Fatigue	Numbness/ tingling	Problems remembering	Feeling more emotional	Sleeping less than usual
Visual problems	Vomiting	Feeling more slowed down	Nervousness	Trouble falling asleep
Balance Problems	Dizziness			

2. Exertional Assessment (Check): The student-athlete exhibits no evidence of return of symptoms with:
__ Cognitive activity: concentration on school tasks, home activities (e.g. TV, computer, pleasure reading)
__ Physical activity: walking, climbing stairs, activities of daily living, endurance across the day

3. Neurocognitive Functioning (Check): The student's cognitive functioning has been determined to have returned to its typical pre-injury level by one or more of the following:
__ Appropriate neurocognitive testing
__ Reports of appropriate school performance/ home functioning (concentration, memory, speed) in the absence of symptoms listed above

4. Balance & Coordination Assessment (Check): Student-athlete is able to successfully perform:
__ Romberg Test OR SCAT2 (Double leg, single leg, tandem stance, 20 secs, no deviations fr proper stance)
__ 5 successive Finger-to-Nose repetitions < 4 sec

I certify that: I am a Licensed Health Care Provider with training in concussion evaluation and management in accordance with current medical evidence (2010 AAP Sport-Related Concussion in Children and Adolescents, 2008 Zurich Concussion in Sport Group Consensus). The above-named student-athlete has met all the above criteria for medical clearance for his/her recent concussion, and as of this date is ready to return to a progressive Gradual Return to Sports Participation program (typically lasting minimum of 5 days).

Provider Name_____

Signature_____ Date:_____

Distribution: __Parent __AD __School Health Room