Concussion – SESC Graded Return to Participation Documentation

Athlete name: ____________________ ______ Date of birth: ___/___/___ Age/Grade: ____/_____

Date of Injury: ____________ Documentation completed by: ________________________ Relationship: ____________________

Graded Symptoms Checklist (GSC)

		Date/Time:	Date/Time:	Date/Time:	Date/Time:	Date/Time:	Date/Time:	Date/Time:	Date/Time:	Date/Time:	Date/Time:
Activity preceding rating											
Symptoms	Headache										
	Pressure in head										
	Neck pain										
	Nausea or vomiting										
	Dizziness										
	Blurred vision										
	Balance problems										
	Sensitivity to light										
	Sensitivity to noise										
	Feel slowed down										
	Fee like "in a fog"										
	"Don't feel right"										
	↓ concentration										
	↓ memory										
	Fatigue/low energy										
	Confusion										
	Drowsiness										
	Difficulty sleeping										
	More emotional										
	Irritability										
	Sadness										
	Nervous/anxious										

Comments:

Concussion – Return to Participation Medical Release

Athlete name: ____________________ ______ Date of birth: ___/___/___ Age/Grade: ____/_____ Date of Injury: ____________

Dear Physician,

This athlete was evaluated and determined to have sustained a concussion on __________. Since that time, the athlete has been monitored for symptoms during academic and sports activities (see reverse side). Please evaluate the athlete and provide appropriate recommendations to be followed by athlete, coaches, teachers, parents, etc. Thank you for your time and assistance!

Additional information can be found at: www.cdc.gov/concussion/HeadsUp/physicians_tool_kit.html

GRADUATED, STEP-WISE RETURN –TO –PARTICIPATION PROGRESSION

1. **No activity:** Complete rest, both physical and cognitive. This may include staying home from school or limiting school hours and/or homework as activities requiring concentration and attention may worsen symptoms and delay recovery.
2. **Light aerobic exercise**: Walking or stationary bike at low intensity; no weight lifting or resistance training.

Before progressing to the next stage the student must be healthy enough to return to school full time.

3. **Sport-specific exercise**: Sprinting, dribbling basketball or soccer; no helmet or equipment, no head impact activities.
4. **Non-contact training**: More complex drills in full equipment. Weight training or resistance training may begin.
5. **Full contact practice**: Participate in normal training activities.
6. **Unrestricted Return-to-Participation/full competition** (please also complete "Return to Participation" Form)

The athlete should spend a minimum of one day at each step. If symptoms re-occur, the athlete must stop the activity. The student must rest for a minimum of 24 hours and then resume activity one-step below where he or she was when the symptoms occurred. ***Graduated return applies to all activities including academics, electronics, sports, riding bikes, playing with friends, PE classes, chores, etc.***

THIS SECTION TO BE COMPLETED BY PHYSICIAN/HEALTH CARE PROFESSIONAL

☐ This athlete **may NOT return** to any sport activity until medically cleared.

☐ Athlete should **remain home from school** to rest and recover until next follow up with physician on ______________________ (date).

☐ Please **allow classroom accommodations,** such as extra time on tests, a quiet room to take tests, and a reduced workload when possible.

Additional Recommendations: ____

☐ Athlete **may begin graduated return at stage circled above.**

Physician/Health Care Professional Signature: ____ **Date**: ______________

Physician/Health Care Professional Name/Title: ____ **Phone**:______________________