Building the Future
CCPS
Carroll County Public Schools

Name_____ School_____
Date of Injury_____
Sport_____
Parent/Guardian Name_____
Phone_____

Medical Clearance for Gradual Return to Sports Participation Following Concussion

To be completed by the Licensed Health Care Provider (LHCP)
(Physician, Neuropsychologist, Nurse Practitioner, Physician's Assistant)

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 as cited by 2010 AAP Sport-Related Concussion in Children and Adolescents, 2008 Zurich Concussion in Sport Group Consensus. (Check each)

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

- ☐ 1. No symptoms at rest
- ☐ 2. No return of symptoms with typical and cognitive activities of daily living
- ☐ 3. Neurocognitive functioning at typical pre-injury level
- ☐ 4. Normal balance and coordination
- ☐ 5. No other medical/neurological complaints/findings

Follow- Up Evaluation (Required for Athletes with Concussions)

All student athletes with concussions must be medically cleared before beginning supervised Gradual Return to Sports/Physical Education Participation (RTP) program. According to COMAR 13A.06.08.01, the following licensed health care providers are permitted to authorize a student athlete to return to play:

(1) A licensed physician trained in the evaluation and management of concussions;
(2) A licensed physician's assistant trained in the evaluation and management of concussions in collaboration with the physician assistant's supervising physician or alternate supervising physician within the scope of the physician assistant's Delegation Agreement approved by the Board of Physicians;
(3) A licensed nurse practitioner trained in the evaluation and management of concussions;
(4) A licensed psychologist with training in neuropsychology and in the evaluation and management of concussions; or
(5) A licensed athletic trainer trained in the evaluation and management of concussions, in collaboration with the athletic trainer's supervising physician or alternate supervising physician and within the scope of the Evaluation and Treatment protocol approved by the Board of Physicians

***NOTE: Carroll County Public Schools only accepts clearance signatures from (1) through (4).**

I certify that: I am aware of the current medical guidance on concussion evaluation and management; 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 supervised Gradual Return to Sports/Physical Education Participation (RTP) program (lasting minimum of 5 days). Note: Students whose symptoms return during the RTP progression will be directed to stop the activity, rest until symptom free. The student will resume activity at the previous stage of the protocol that was completed without recurrence of symptoms. Students with persistent symptom return will be referred to their health care provider for evaluation.

Date: _____ **LHCP Name**_____

Signature_____ Phone:_____

Distribution: White–Parent; Yellow–Athletic Trainer; Pink–School Health Room; Goldenrod–Athletic Director

RETURN FORM TO SCHOOL NURSE