Florida High School Athletic Association

Revised 06/15

Post Head Injury/Concussion Initial Return to Participation

(Page 1 of 2)

This form is to be completed by an appropriate health care provider (AHCP) trained in the latest concussion evaluation and management protocols as defined in FHSAA policy 40.2 for any student-athlete that has sustained a concussion and must be kept on file at the student-athlete's school. The choice of AHCP remains the decision of the parent/guardian or responsible party of the student-athlete.

Athlete Name: _____ DOB: _____/_____/_____ Injury Date: _____/_____/_____

Sport: _____ School: _____ Level (Varsity. JV, etc.): _____

I (treating physician) certify that the above listed athlete has been evaluated for a concussive head injury, and currently is/has:
(All Boxes MUST be checked before proceeding)

Asymptomatic

Asymptomatic

☐ –

Rehabilitation stage	Functional exercise at each stage	Objective	Date completed	Initials
1. No Activity	Rest; physical and cognitive	Recovery	Noted above	Signed above
2. Light aerobic exercise	Walking, swimming, stationary bike, HR<70% maximum; no weight training	Increased heart rate		
3. Sport-specific exercise	Non-contact drills	Add movement		
4. Non-contact training	Complex (non-contact) drills/practice	Exercise, coordination and cognitive load		
5. Full contact practice	Full contact practice	Restore confidence and simulate game situations		
6. Return to full activity	Return to competition	**After completion of the steps above; Form AT18, Page 2 must be completed by physician**		

I attest the above named athlete has completed the graded return to play protocol as dated above.

Athletic Trainer / Coach Name: _____ AT License Number: _____ Phone: _____

(If coach) AD/Principal Name: _____ School: _____Phone: _____

Athletic Trainer / Coach Signature: _____ Date: _____/_____/_____

Athlete Signature: _____ Date: _____/_____/_____

Physician Reviewed:

_____

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Return to Competition Afýdavit

Student-Athlete's Name: _____

Date of Birth: _____/_____/_____ Injury Date: _____/_____/_____

Formal Diagnosis: _____

School: _____

Sport: _____

I certify that I have reviewed the signed graded return to activity protocol provided to me on behalf of the athlete named above. This athlete is cleared for a complete return to **full-contact physical activity** as of _____/_____/_____.

This student-athlete is instructed to stop play immediately and notify a parent, licensed athletic trainer or coach and to refrain from activity should his/her symptoms return.

Physician Name: _____

Physician Signature:_____ License No.: _____

Phone: (_____) _____ Fax: (_____) _____ E-mail: _____

Date: _____/_____/_____