Name: Concussion Return to Play – Contact/ Collision

Date/Time/Location					
Specific Activities Performed by Athlete					
Clinical Exam Questions and Findings: Headache or pressure in head, Dizziness, Confusion, Sensitivity to light/Noise, Imbalance	Y N Headache Y N Dizziness Y N Confusion Y N Sensitivity Light Noise Y N Imbalance	Y N Headache Y N Dizziness Y N Confusion Y N Sensitivity Light Noise Y N Imbalance	Y N Headache Y N Dizziness Y N Confusion Y N Sensitivity Light Noise Y N Imbalance	Y N Headache Y N Dizziness Y N Confusion Y N Sensitivity Light Noise Y N Imbalance	Y N Headache Y N Dizziness Y N Confusion Y N Sensitivity Light Noise Y N Imbalance

Day 1: Light Aerobic Activity:
Light aerobic activity without resistance training. 20 min. bike

Day 2: Moderate Aerobic Activity:
25 min. run with sport specific movements without head impact.

Day 3: Intense Cardio Activity:
Non-contact sports drills & allowed weight training.

Day 4: Full Practice: Full Gear – Contact

Day 5: Full Participation: Competition

ImPACT Testing:
Y N
Dates:
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_____
_____

Physician Clearance Communication:

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_____

Date/Time/Location					

Name: Concussion Return to Play – Contact/ Collision

Specific Activities Performed by Athlete					
Clinical Exam Questions and Findings: Headache or pressure in head, Dizziness, Confusion, Sensitivity to light/Noise, Balance Problems, Imbalance	Y N Headache Y N Dizziness Y N Confusion Y N Sensitivity Light Noise Y N Imbalance	Y N Headache Y N Dizziness Y N Confusion Y N Sensitivity Light Noise Y N Imbalance	Y N Headache Y N Dizziness Y N Confusion Y N Sensitivity Light Noise Y N Imbalance	Y N Headache Y N Dizziness Y N Confusion Y N Sensitivity Light Noise Y N Imbalance	Y N Headache Y N Dizziness Y N Confusion Y N Sensitivity Light Noise Y N Imbalance

Clinical Notes:

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