

Name: _____

Concussion Return to Play – Non-Contact

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 Headache	Y N Headache	Y N Headache	Y N Headache
	Y N Dizziness	Y N Dizziness	Y N Dizziness	Y N Dizziness	Y N Dizziness
	Y N Confusion	Y N Confusion	Y N Confusion	Y N Confusion	Y N Confusion
	Y N Sensitivity	Y N Sensitivity	Y N Sensitivity	Y N Sensitivity	Y N Sensitivity
	Light Noise	Light Noise	Light Noise	Light Noise	Light Noise
	Y N Imbalance	Y N Imbalance	Y N Imbalance	Y N Imbalance	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:

Modified workout with team & allowed weight training.

Day 4: Full Practice: Full Workout with team

Day 5: Full Participation: Competition

ImPACT Testing:
Y N

Dates:

Physician Clearance Communication:

Name:

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

Clinical Notes:
