Post Head Injury/Concussion
Initial Return to Participation

JPA-25

Student Name: _____ School: _____ DOB: ____/____/____

Sport: _____ Date of Injury: _____

I certify that the above listed student athlete has been evaluated for a concussive head injury (per Education Code 49475, see page 3), and is currently asymptomatic with a normal neurological examination and off of all medications related to this concussive injury. **The student athlete named as above is cleared to begin a gradual return to participate protocol (outlined below) under the supervision of an athletic trainer, coach or other health care professional as of the date indicated below.**

Date cleared for Gradual Return to Participate Protocol: _____

If the student athlete experiences a return to any of his/her concussion symptoms while attempting a gradual return to participate, the student athlete is instructed to stop play immediately and notify a parent, athletic trainer or coach.

Physician Name: _____ Signature/Degree: _____

Phone : _____ Fax: _____ Date: _____

Return to Play Progression

This protocol must be performed under supervision. Please initial and date the box next to each completed step on the next page.

Once the student athlete has completed full practice (i.e. stage III) please sign and date below and return this form to the student athlete's physician (MD/DO) for review and request the physician complete the return to competition form for the student athlete to resume to full activity.

It may take several weeks to months to work through the entire 4-step progression.

I attest the above-named student athlete has completed the gradual return to participate protocol as dated on the next page.

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

(if athletic trainer) AT License Number: _____ Phone: _____

(if coach) AD/Principal Name: _____ School: _____ Phone: _____

Student Athlete Parent/Guardian Signature: _____ Date: _____

CIF Concussion Return to Play (RTP) Protocol

CA STATE LAW AB 2127 (Effective 1/1/15) STATES THAT RETURN TO PLAY (I.E., COMPETITION) CANNOT BE SOONER THAN 7 DAYS AFTER EVALUATION BY A PHYSICIAN (MD/DO) WHO HAS MADE THE DIAGNOSIS OF CONCUSSION.

Instructions:

- This *graduated return to play protocol* MUST be completed before you can return to FULL COMPETITION.
  - A certified athletic trainer (AT), physician, and/or identified concussion monitor (e.g., coach, athletic director), must monitor your progression and initial each stage after you successfully pass it.
  - Stages I to II-D take a *minimum* of 6 days to complete.
  - You must be back to normal academic activities before beginning Stage II, unless otherwise instructed by your physician.
  - You must complete one full practice *without restrictions* (Stage III) before competing in first game.
- After Stage I, you cannot progress more than one stage per day (or longer if instructed by your physician).
- If symptoms return at any stage in the progression, IMMEDIATELY STOP any physical activity and follow up with your school's AT, other identified concussion monitor, or your physician. In general, if you are symptom-free the next day, return to the previous stage where symptoms had not occurred.
- Seek further medical attention if you cannot pass a stage after 3 attempts due to concussion symptoms, or if you feel uncomfortable at anytime during the progression.

You must have written physician (MD/DO) clearance to begin and progress through the following Stages as outlined below (or as otherwise directed by physician)				
Date & Initials	**Stage**	**Activity**	**Exercise Example**	**Objective of the Stage**
	I	No physical activity for at least 2 full symptom-free days **AFTER** you have seen a physician	• No activities requiring exertion (weight lifting, jogging, P.E. classes)	• Recovery and elimination of symptoms
	II-A	Light aerobic activity	• 10-15 minutes *(min)* of walking or stationary biking. • **Must be performed under *direct supervision* by designated individual**	• Increase heart rate to no more than 50% of perceived maximum *(max)* exertion (e.g.,< 100 beats per min) • Monitor for symptom return
	II-B	Moderate aerobic activity *(Light resistance training)*	• 20-30 min jogging or stationary biking • Body weight exercises (squats, planks, push-ups), max 1 set of 10, no more than 10 min total	• Increase heart rate to 50-75% max exertion (e.g.,100-150 bpm) • Monitor for symptom return
	II-C	Strenuous aerobic activity *(Moderate resistance training)*	• 30-45 min running or stationary biking • Weight lifting ≤ 50% of max weight	• Increase heart rate to > 75% max exertion • Monitor for symptom return
	II-D	Non-contact training with sport-specific drills *(No restrictions for weightlifting)*	• Non-contact drills, sport-specific activities (cutting, jumping, sprinting) • No contact with people, padding or the floor/mat	• Add total body movement • Monitor for symptom return
Minimum of 6 days to pass Stages I and II. Prior to beginning Stage III, please make sure that written physician (MD/DO) clearance for return to play, after successful completion of Stages I and II, has been given to your school's concussion monitor				
	III	Limited contact practice	• Controlled contact drills allowed (no scrimmaging)	• Increase acceleration, deceleration and rotational forces • Restore confidence, assess readiness for return to play • Monitor for symptom return
		Full contact practice Full unrestricted practice	• Return to normal training, with contact • Return to normal unrestricted training	
MANDATORY: You must complete at least ONE contact practice before return to competition, or if non-contact sport, ONE unrestricted practice *(If contact sport, highly recommend that Stage III be divided into 2 contact practice days as outlined above)*				
	IV	Return to play (competition)	• Normal game play (competitive event)	• Return to full sports activity without restrictions

Return to Competition Affidavit

Student Athlete's Name: _____

DOB: ____/____/____ Injury Date: _____

Formal Diagnosis: _____

School: _____

Sport: _____

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

Education Code 49475 (1) An athlete who is suspected of sustaining a concussion or head injury in an athletic activity shall be immediately removed from the athletic activity for the remainder of the day, and shall not be permitted to return to the athletic activity until he or she is evaluated by a licensed health care provider who is trained in the management of concussions and is acting within the scope of his or her practice. The athlete shall not be permitted to return to the athletic activity until he or she receives written clearance to return to the athletic activity from that licensed health care provider.

If the licensed health care provider determines that the athlete sustained a concussion or a head injury, the athlete shall also complete a graduated return-to-play protocol of no less than seven days in duration under the supervision of a licensed health care provider.

This student athlete is instructed to stop play immediately and notify a parent, 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: _____