Western Ohio Junior Football Conference

Concussion Return to Play Form

CONCUSSION EVALUATION AND RELEASE TO PLAY FORM FOR LICENSED HEALTH CARE PROVIDERS

(SECTION ONE: Completed by Head Coach or Assistant Coach)

Student Name (**PRINT**): _____ Date: _____

Club:_____ Grade: _____ Color:_____Number of Past Concussions: _____

Brief Description by Head Coach or Coach of How Injury Occurred and Why Concussion is suspected:

_____

(SECTION TWO: Completed by Licensed Health Care Provider)

Per WOJFC, a player who is suspected of suffering a concussion can **NOT** return to play until that athlete has been evaluated by a **licensed health care provider trained in the evaluation, management of concussions and head injuries.** The "WOJFC Concussion Return to Play Form" must be completed and signed by the health care provider who evaluated the athlete and include the return to play date. The completed "WOJFC Concussion Return to Play Form" for that athlete must be presented to the WOJFC before the athlete can return to play.

Health Care Provider Name: _____

License Number: _____ Licensing Board: _____

I have evaluated the above mentioned student athlete and the student athlete is:

_____ **NOT** cleared to participate in any sports-related activities (including gym class) until seen for a follow-up exam

_____ Cleared, as of today, to return to all activities, including sports, without restrictions

_____ Cleared to return to all activities, including sports, without restrictions, On the following date* -_____

_____ Cleared to return to sports following the schedule below:

Step 1: May participate in light activity on the following date* - _____
(Examples: 10 minutes on an exercise bike, walking, or light jogging; but no weight lifting, jumping or hard running)

Step 2: May participate in moderate activity on the following date* - _____
(Examples: Moderate intensity activity on an exercise bike, jogging or weight lifting {reduced time and/or weight than normal})

Step 3: May participate in heavy; non-contact physical activity on the following date* -_____
(Examples: Sprinting, running, high-intensity exercise bike, and weight lifting; but no contact sports)

Step 4: May return to practice and full contact in a controlled practice setting on the following date* - _____

Step 5: May return to full game and/or scrimmage play on the following date* - _____

Other – please list:_____

*** Please note that if signs and symptoms of a concussion occur, the student must return to the previous stage and parents must contact the licensed health care provider for instructions.**

_____ _____

(Signature of Health Care Provider) (Date)