Florida High School Athletic Association

Revised 03/23

Post Head Injury/Concussion Initial Return to Participation

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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
- ☐ Normal neurological exam
- ☐ Off medications related to this concussion
- ☐ Returned to normal classroom activity
- ☐ Yes ***or*** ☐ N/A Neuropsychological testing (as available) has returned to baseline

The athlete named above is cleared to begin a graded return to play protocol (outline below) under the supervision of a licensed athletic trainer, physical therapist, other health care professional as of the date indicated below. If the athlete experiences a return of any of his/ her concussion symptoms while attempting a graded return to play, the athlete is instructed to stop play immediately and notify a parent, licensed athletic trainer or coach.

Physician Name: _____ Signature (MD/DO)_____

Phone: _____ Email/Fax: _____ Evaluation Date: _____

Graded Return to Play Protocol

Each step, beginning with step 2, should take at least 24 hours to complete. If the athlete experiences a return of any concussion symptoms, they must immediately stop activity, wait at least 24 hours or until asymptomatic, and drop back to the previous asymptomatic level. This protocol must be performed under supervision, as noted above. Please initial and date the box next to each completed step.

Once the athlete has completed full practice i.e., stage 5, please sign and date below and return this form (in-person, fax, or electronic as agreed upon with the treating physician) to the athlete's physician (MD/ DO) for review and request the physician complete the return to competition form for the athlete to resume full activity.

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 (MD/DO) familiar with concussion management.**		

I attest the above-named athlete has completed the graded return to play protocol as dated above.
This form is not valid until all boxes are complete, initialed, and signed.

Supervising Healthcare Provider Name: _____ License Number: _____ Phone: _____

Supervising Healthcare Provider Signature: _____ Date: ___/___/_____

Athlete Signature: _____ Date: ___/___/_____

Physician Reviewed:

_____

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Return to Competition Certification

Student-Athlete's Name: _____

Date of Birth: ____/____/_____ Injury Date: ____/____/_____ Diagnosis: _____

School: _____

Sport: _____

- *Completing this form certifies that I have reviewed the FHSAA concussion protocols in place for graded return to play including the need for supervised progression as outlined on page 1 of this form. I attest that I have reviewed the signed graded return to activity protocol provided to me on behalf of the athlete named above. Further, I have reviewed the appropriate procedures for full return to competition with the student-athlete and parent including the risks associated with return to sport after a concussion*.

SHOULD ANY CONCUSSION RELATED SYMPTOMS RETURN, THIS STUDENT-ATHLETE IS INSTRUCTED TO STOP PLAY IMMEDIATELY AND NOTIFY A PARENT, LICENSED ATHLETIC TRAINER OR COACH AND TO REFRAIN FROM ACTIVITY

This athlete is cleared for a complete return to **full-contact physical activity** as of: _____/_____/_____

This date is published once athlete has fulfilled the FHSAA concussion protocol and is released from medical care

Physician (*MD/DO only*) Name: _____

Physician Signature: _____ License No.: _____

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

Date Signed: ____/_____/___

This form is not valid until all fields are completed
This form may be transmitted electronically