Physician Release form for Post-Concussion Assessment

Student/Athlete: ____ School: ______________________________

School officials name and title: ____ Date: ________________

Mechanism of injury: ____

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SCAT 3 assessment form attached when performed by athletic trainer.

PHYSICIANS SECTION: Note to Physician: This athlete demonstrated signs, symptoms or behaviors of concussion at his/her school and is seeing you for professional evaluation and recommendations for care. Per Kansas Law, Kansas State High School Activities Association, and the National Federation of High Schools, any athlete who exhibits signs, symptoms or behaviors consistent with a concussion shall be immediately removed from the contest (or practice) and shall not return to play until cleared by an appropriate health care professional.

Initial Physician Assessment:

________ I find **NO evidence of concussion**. The student **is cleared for return to full participation** 24 hours after signs, symptoms, or behaviors were first noted.

________The student has been examined by me and **is diagnosed with a concussion and may NOT return to sports or physical activities** (including but not limited to practices, gym class, running, jumping, or weight lifting) until further notice.

Returning to School. Until the student has fully recovered, the following academic supports are recommended: *(check all that apply)*

____ No return to school. Return on (date) ____

____ Shortened day – recommend _____hours per day until (date) ______________________________

____ Additional recommended academic supports (e.g. rest breaks during the day, maximum length of nightly homework, limitations on testing/standardized testing): ____

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Follow-up Physician Assessment:

_________ Follow-up examination indicates that the student **continues to demonstrate signs, symptoms, or behaviors of concussion** and **MAY NOT** return to sports or physical activity **until further notice**.

________ Follow-up examination indicates the student demonstrates continued recovery from concussion. The student **may begin graduated return-to-play** protocol with the Athletic Trainer. The student is **to RETURN to the PHYSICIAN for a FOLLOW-UP appointment,** after successful completion of the graduated return to play protocol and prior to **return-to-play.**

_________ Follow-up examination indicates the student demonstrates recovery from concussion and **may begin graduated return-to-play** protocol. The **Athletic Trainer MAY CLEAR the student to return-to- play** without any restriction **upon successful completion** of the **graduated return to play protocol.**

________ Follow-up examination indicates the student demonstrated complete recovery from concussion and **may return to all activities without restriction.**

Name of Physician: ____ Phone Number: _______________________

Signature of Physician:____ Date:________________________

Reference: Part or all of the above form is taken from the following different websites:

Center for Disease Control and Prevention	www.cdc.gov
Kansas State High School Activities Association	www.KSHSAA.com
National Federation of State High School Association	www.NFHS.com

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