Physician Release form for Post-Concussion Assessment

Student/Athlete: ____________________________ School: ____________________________
School officials name and title: ____________________________ Date: ___________
Mechanism of injury: ____________________________

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):
__________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

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 Rev. 02/2016