Physician Concussion Evaluation

Unionville Chadds-Ford School District Athletic Training

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Date:_____

Dear Physician:

_____has presented to the athletic training staff with the following concussion signs/symptoms as a result of _____ while participating in _____.

As per Unionville-Chadds Ford School District Policy & Pennsylvania Law, he/she must be evaluated by an appropriate medical professional **trained in the evaluation and management of concussion**. Please note, our policy is adapted from the Zurich Concussion Consensus Statement recommending that anyone with one or more concussion signs/symptoms must be evaluated for a concussion.

Headache Nausea Balance Problems Dizziness Visual Disturbances Light Sensitivity 'Fogginess' Noise Sensitivity Difficulty Concentrating Sleep Disturbances Behavioral Changes Pressure in Head Slurred Speech Amnesia Fatigue/Drowsiness Vomiting Loss of Consciousness Other:_____

Number of Previous Head Injuries: _____ Dates:_____

UCFSD Return to Play Guidelines

1. Asymptomatic (without use of medications to mask symptoms).
2. Completion of the Return to Play Guidelines (listed below)- *supervised by an athletic trainer, physical therapist, or physician.*

- ImPACT Scores may be used in conjunction with the above protocol

Return to Play Progression

1. Completion of full day of normal cognitive activities (school day, studying for tests, watching practice, interacting with peers) without re-emergence of any signs or symptoms.
2. Light exercise, including walking or riding an exercise bike. No resistance training or weight lifting.
3. Sport Specific Exercises or running in the gym and/or on the field. No head impact activities. No helmet or other equipment.
4. Non-contact training drills in full equipment. Resistance/weight training can begin.
5. Normal practice or training activities.
6. Return to play involving normal exertion OR game activity.

*Each step is separated by 24 hours. If any symptoms occur it may be necessary for them to repeat steps and/or revisit his/her medical professional.

.___ I agree the athlete is cleared once he/she completes the UCFSD Return to Play Guidelines listed above.
___ I have different return to play recommendations. ***(please specify below or on a separate form)***

Physician's Name:_____ Physician's Signature: _____Date:_____

PLEASE TURN OVER TO COMPLETE THE ACCOMMODATIONS PORTION OF THE FORM!