AYSO Concussion Evaluation and Release Form

This athlete is suspected to have sustained a concussion and therefore according to California State Law must be evaluated and cleared by a physician (MD or DO) who is trained in the evaluation and management of concussion. All medical providers are encouraged to review the CDC site (http://www.cdc.gov/headsup/providers) if there are any questions regarding the latest information on the evaluation and care of an athlete following a concussion.

The following 2 page form is a **REQUIRED** document by AYSO Region 58. This document and the AYSO Participation Release Form (which is available online at: http://www.aysovolunteers.org/ayso-participation-return-to-play-release-form/) must both be signed and returned to the athlete's coach and then forwarded to the Regional Safety Director. Regional Safety Director approval is required before the athlete may return to AYSO Soccer

The front page is to be completed by Parent, Coach, Referee, Athletic Trainer or whomever completed the AYSO Incident Report. The back page is to be completed by the treating physician.

Athlete's Name: _____ Date of Birth: _____ Gender: ____

Division: _____ Team: _____ Coach: _____

Person/volunteer completing this form (Name and title): _____

He/she was removed from play on (date):_____ by: ☐ coach ☐ referee ☐ parent ☐ athletic trainer

due to having the following suspected mechanism of head injury: _____

_____

and displaying the following signs or symptoms of concussion: ☐ headache ☐ dizziness

☐ loss of consciousness ☐ confusion ☐ memory loss ☐ fatigue

☐ blurry vision ☐ ringing in the ears ☐ nausea ☐ vomiting

☐ other: _____

Please remember that a concussion is a clinical diagnosis based on history (including mechanism of injury) and signs and symptoms (which may occur immediately or may be delayed). Loss of consciousness is not required for a concussion.

(OVER)

MEDICAL PROVIDER'S RECOMMENDATION (to be completed by the treating MD or DO):

Having reviewed the front page of this 2 page form and after examining the athlete, I have determined that (Athlete's name): _____ has the following diagnosis:

☐ Concussion

☐ Other: (please specify specific medical diagnosis if not concussion)_____

RETURN TO PLAY: Per California State Law, ALL CONCUSSED ATHLETES MUST COMPLETE A 6 STEP (7 DAYS MINIMUM) RETURN TO PLAY PROTOCOL. THE ATHLETE MUST BE SYMPTOM FREE FOR 48 HOURS to complete step 1 of the return to play protocol before resuming any form of physical activity. The athlete may not return to practice until the appropriate 6 step return to play protocol is completed.

Example of Graduated Return to Play Progression

Stage	Exercise
1	No physical activity for 48 hours
2 (Low levels)	Walking, light jogging, light stationary cycling, light weightlifting (lower weight, higher reps, no bench, no squat)
3 (Moderate Levels)	Moderate jogging/ brief running, moderate-intensity weightlifting (reduced time and/or weight from your typical routine).
4 (Heavy Levels)	Sprinting/ running, high intensity stationary biking, regular weightlifting routine, non-contact sports-specific drills (in 3 planes of movement)
5	**Full contact in controlled practice environment**
6	**Full contact in game play**

More than one evaluation is typically necessary for medical clearance for concussion as symptoms may not be fully present for days. Due to the need to monitor concussions for recurrence of signs and symptoms with cognitive or physical stress, **Emergency Room and Urgent Care physicians** typically do not make clearance decisions at time of the first visit.

Please check appropriate boxes:

☐ Athlete must return for follow-up visit prior to starting Return to Play Protocol. (Prior to step 2)

☐ Athlete may start Return to Play protocol (step 2) when he/she is symptom free or

after (date) _____ if remains symptom free

☐ Athlete must return for follow-up visit prior to starting full contact practice (Prior to step 5)

☐ Athlete has completed Return to Play protocol and/ or is clear for full return to contact sports

Additional comments/instructions: _____

Physician's Name (please print): _____ Office Phone Number: _____

I certify that I am an MD or DO trained in the evaluation and management of concussions: Please affix physician's stamp or business card to this form.

Physician's Signature (required): _____ Date: _____

This Portion is for Regional Use Only

Received by AYSO Region 58 Safety Director:_____
Signature: _____ Date: _____