**The Greenville Hurricanes Athletic Association   
Concussion Return to Play Form**

This form is adapted from the Acute Concussion Evaluation (ACE) care plan on the CDC website (www.cdc.gov/injury). All medical providers are encouraged to review this site if they have questions regarding the latest information on the evaluation and care of the scholastic athlete following a concussion injury. Please initial any recommendations that you select.

Student-Athlete’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_ /\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injury \_\_\_\_\_\_ /\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_

This Return-to-Play Plan Is Based On Today’s Evaluation

Date of Evaluation \_\_\_\_\_\_ /\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_

Care Plan Completed By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Return to this office (Date/Time) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Return to School on (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Return-to-Sports Note

1. Athletes should not return to practice or play the same day that their head injury occurred.

2. Athletes should never return to play or practice if they still have any Symptoms.

3. Athletes, be sure that your coach and/or athletic trainer are aware of your injury, symptoms, and has the contact information for the treating physician.

The following are the return to sports recommendations at the present time:

School:

\_\_\_\_\_\_ Physical Education Do NOT return to PE class at this time.

\_\_\_\_\_\_ May return to PE Class at this time.

Sports Participation:

\_\_\_\_\_\_ Do Not return to sports practice or competition at this time.

\_\_\_\_\_\_ May gradually return to sports practice under the supervision of the healthcare provider

for your school or team.

\_\_\_\_\_\_ May be advanced back to competition after phone conversation with attending

physician.

\_\_\_\_\_\_ Must return to Physician for final clearance to return to competition.

\_\_\_\_\_\_ CLEARED for FULL Participation in all activities without restriction.

Medical Office Information (Please Print/Stamp)

Physician’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Office Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_