

Diagnosed Concussion Injury Form 1

Return to Learn Step 2B

Return to Physical Activity Step 3

This form is to be completed by the parent/guardian of the student named in this document before the student is permitted to proceed to Step 2B/Step 3 and returned to the school Principal/designate.

Name of Student _____

Grade _____ School _____

Please indicate your acknowledgement and agreement by checking all boxes confirming the following:

Parental Consent

Step	Date	Parent/Guardian Signature
<input type="checkbox"/> My child/ward has completed Step 1 (at least 24 hours of rest at home). His/her symptoms have improved. I have communicated this information to the school. I agree that my child can proceed to Step 2A: Return to Learn.		
<input type="checkbox"/> My child/ward has now completed Step 2A and no symptoms are present. I agree that he/she can proceed to Step 2B: Return To Learn. I agree that my child/ward can proceed to Step 3: Return to Light Aerobic Activity.		

If my child/ward experiences a return of concussion-like symptoms, I agree to remove my child/ward from the school for at least 24 hours and to seek the advice of my child's/ward's medical doctor/nurse practitioner for their recommendation to return to the appropriate step in the return to learn/return to play process and to advise the Principal of this medical decision.

Parent/Guardian Name (printed) _____

Parent/Guardian Signature _____ Date _____

Please attach additional information if available.