Medical Assessment for Return to Learn/Play Readiness

To be given to the parent/guardian of the student named in this document for completion by a medical doctor or a nurse practitioner before the student is permitted to return to physical activity.

Name of Student: Grade:

School: Date of Injury:

As a result of my child's head injury (signs/symptoms of concussion observed and reported by school personnel), I have consulted with a medical doctor/nurse practitioner to assess the head injury to determine the readiness of my child to return to learning and play activities.

Name of Medical Doctor/Nurse Practitioner:

Address of Treatment Centre: Date of Appointment:

Phone Number of Treatment Centre:

Results of the medical appointment:

☐ I have examined my patient named above and confirm he/she is concussion symptom free and he/she is able to return to regular physical education class/intramural and non-contact sports teams and for training/practices for contact competitive sports at this time.

Some symptoms are still present and the student may return to light aerobic activities (Step 3)

Medical Recommendations for Return to Physical Activity

Note: A signed doctor's note will be required before the child can return to activities that involve physical contact. This would involve STEPS 5 & 6. Please attach additional information if the student is able to return to full contact competitive sports immediately.

☐ I have observed and monitored my child and have determined that there are no concussion-like signs or symptoms. **I have chosen not to consult with a medical doctor or a nurse practitioner and am permitting my child to return to light physical activity (Step 3).**

☐ I have observed and monitored my child and have determined that there are no concussion-like symptoms. **I have chosen not to consult with a medical doctor or nurse practitioner. I am permitting my child to return to full learning and play activities (Step 4).**

Parent/Guardian name (printed) Parent/Guardian (signature) Date