SCYR's Physician Concussion Clearance Form

Document must be signed by a Physician licensed in the state of California.

Athlete Name: _____ Date/Time of Injury: _____

DOB: _____ Today's Date: _____ Club & Team:_____

Injury Details:	
History of previous concussion or head injury?	
Does the athlete have an ImPACT or SCAT 5 baseline?	

Symptoms Observed or Reported

___ Vacant Stare ___ Temporary loss of consciousness ___ Confusion/foggy feeling ___ Nausea
___ Vomiting ___ Headache or pressure in the head ___ Amnesia ___ Dizziness ___Fatigue
___ Slurred Speech ___Delayed response to questions ___ Appeared dazed ___ Light/noise sensitivity
___ Concentration/memory problem ___Irritability or personality change ___ Other _____
___ SCAT 5 Attached ___ VOMS assessment attached

Signature: _____ Name_____ **ATC/ Coach**

To Be Completed by Physician:

Athlete must be evaluated by an MD or DO trained in the evaluation and management of concussions who is acting within his/her scope of practice and is familiar with current California concussion legislation. MD/DO cannot be the patient's immediate family member

At this time is the athlete is experiencing any concussion signs/symptoms**: Y/N**
Is the athletes ImPACT / SCAT5 score within baseline ranges: **Yes No N/A**

Please initial all of the following that apply

	Athlete has a concussion and may not return to physical activity or rugby practices/matches until medically cleared (SoCal Youth Rugby requires full 2 week rest period for any concussion, then 4 stage Graduated Return to Play Protocol) - **Further Clearance Required**
	Athlete may begin Graduated Return To Play on (date:_____) after being symptom free and having completed the **two week** mandatory rest period. Upon successful completion the athlete is cleared and may return to play without further clearance.
	Athlete has successfully completed both the two week mandatory rest period and Graduate Return to Play and is cleared to return to play immediately.
	Athlete has been evaluated and assessed as NOT having sustained a concussion and may return to play immediately

Physician Name: _____ Phone #:_____

Physician Signature: _____ Date: _____

Physician Stamp

SCYR Graduated Return to Play Progression

Before beginning the gradauted retuurn to play protocol, athlete must have completed 2 weeks rest period and have been 100% symptom free for at least 2 days. It is required that the athlete has been evaluated by a physician prior to beginning the return to play protocol. Common concussion symptoms to monitor the athlete for include but are not limited to: headache, dizziness, problems focusing or remebering, neck pain, confusion, or irritabity, unusual behavior, visual problems such as blurry or double vision, complaint or feeling foggy mentally or simply "not feeling right."

Athlete should be monitored by and the form should be completed by a parent or coach.

Date	Stage		Exercise	Heart Rate
	0	Two Week Rest Period	No physical activity other than that prescribed by a Health Care Provider. Athlete must be symptom free for two full days prior to progressing to Stage 1.	<50% of Max
	1	Light to Moderage Aerobic Activity	20-30 minutes of stationary bike or jogging, 10 minutes of body weight exercises	<75% of Max
	2	Strenous Aerobic Activity	30-45 mintues of running, Weight lifting at <50% of max.	>75% of Max
	3	Sport Specific Non Contact	Non-contact practice/drills. Running, passing, catching, conditioning	>75% of Max
	4	Full Practice	Unrestricted rugby practice including tackling, rucks, etc.	

Return to Compitition: Rugby Match

Monitor athlete for symptoms and ONLY progress to next stage after 24 hours and athlete has remained symptom free.

Once all stages of return to play progression are complete, scan and email the form to Christine Mitchell at *christine@socalyouth.rugby* along with the physician clearance form and the athlete will be cleared to return to rugby matches and competition.

Athlete Name:	Club:
Date of Injury:	
Monitored by:	Signature:
Date of Completion:	