

# CAMBRIDGE MINOR LACROSSE CONCUSSION EVALUATION

## AND RETURN TO PLAY FORM

(SECTION ONE: Completed by Team Trainer)

Athlete's Name: \_\_\_\_\_

Date: \_\_\_\_\_ Sport's Team: \_\_\_\_\_

Number of Past Concussions: \_\_\_\_\_

Brief Description by Team Trainer of How Injury Occurred and Why Concussion is Suspected:

\_\_\_\_\_

(SECTION TWO: Completed by Licensed Health Care Provider)

A athlete who is suspected of suffering a concussion may not return to play until athlete has been evaluated by a licensed health care provider trained in the evaluation and management of concussions and head injuries, receives a written clearance to return to play from the health care provider who evaluated the athlete, and at least twenty-four (24) hours have passed since the athlete was removed from play.

Health Care Provider Name: \_\_\_\_\_

License Number: \_\_\_\_\_ Licensing Board: \_\_\_\_\_

I have evaluated the above mentioned athlete and the athlete is:

\_\_\_\_\_ **NOT** cleared to participate in any sports-related activities (including gym class) until seen for a follow-up exam

\_\_\_\_\_ Cleared, as of today, to return to all activities, including sports, without restrictions

\_\_\_\_\_ Cleared to return to all activities, including sports, without restrictions,  
on the following date\* - \_\_\_\_\_

\_\_\_\_\_ Cleared to return to sports following the schedule below:

Step 1: May participate in light activity on the following date\* - \_\_\_\_\_

(10 minutes on an exercise bike, walking, or light jogging; but no weight lifting, jumping or hard running)

Step 2: May participate in moderate activity on the following date\* - \_\_\_\_\_

(Moderate intensity activity on an exercise bike, jogging or weight lifting {reduced time and/or weight than normal})

Step 3: May participate in heavy; non-contact physical activity on the following date\* - \_\_\_\_\_

(Sprinting, running, high-intensity exercise bike, and weight lifting; but no contact sports)

Step 4: May return to practice and full contact in a controlled practice setting

on the following date\* - \_\_\_\_\_

Step 5: May return to full game play on the following date\* - \_\_\_\_\_

\* Please note that if signs and symptoms of a concussion occur, the athlete must return to the previous stage and parents must contact the licensed health care provider for instructions.

\_\_\_\_\_

(Signature of Health Care Provider)

\_\_\_\_\_

(Date)