Utah Youth Soccer Association

Return to Play and Concussion Clearance Form

Athlete Information

_____ _____/_____/_____ U-_____ _____

Athlete's Name *Date of Birth* *Club Name / Event*

_____/_____/_____ _____/_____/_____ _____ AM PM

Date of Injury *Date of Initial Exam* *Time of Initial Exam*

Evaluation and Diagnosis

_____ _____ _____ __/__/____

Health Professional (print name) *Health Professional (signature)* *Qualification: (M.D., A.T.C., etc.)* *Date*

Phone: (_____) _____ -_____ Email: _____

Health Professional Phone Number *Health Professional Email*

☐ The above-named athlete **HAS** sustained a concussion on the date noted above and has been evaluated by me. This athlete is not medically released for participation until they have successfully completed the Return To Play Protocol under the supervision of their parent/guardian and received a final signature from a Q.H.C.P. (Qualified Healthcare Provider) who has reviewed the athletes progress and releases the athlete to return to full competition.

_____ _____ _____/_____/_____

Health Professional ***Phone Number*** ***Date***

☐ The above-named athlete has been evaluated by a Q.H.C.P. and was determined to have sustained a concussion. They have completed the full return to play protocol and are **CLEARED** to return to full participation with no restrictions.

_____ _____ _____/_____/_____

Health Professional – signature of clearance ***Phone Number*** ***Date***

☐ The above-named athlete has been evaluated by a Q.H.C.P. and was determined to **NOT** have sustained a concussion and is cleared to return to participation.

_____ _____ _____/_____/_____

Health Professional – signature of clearance ***Phone Number*** ***Date***

Parent/Guardian Release

The athlete will be released to, _____ who is an adult over the age of 18, and is capable of monitoring the above named athletes medical condition. If the above-named adult is not the parent/legal guardian of the above-named athlete, then they are responsible for monitoring the named athlete's progress until a parent/legal guardian is present, or until athlete is under the care of a medical professional. If the individual's symptoms worsen then immediate medical attention is needed.

☐ Called and spoke with parent/guardian ☐ Emailed parent/guardian ☐ Other: _____

Phone: (_____) _____ -_____ Email: _____ Date: _____

"Overview" of the Return to Play Process

Checklist: returning a player back to the field

- ☐ **Step 1.** Initial Evaluation from a Qualified Health Care Provider (Q.H.C.P).
  - ➢ Review **UYSA Concussion Instruction and Return to Play Clearance Form**
- ☐ **Step 2.** Follow up visits with a Q.H.C.P. as needed until the athlete is *symptom free*.
  - ➢ *After* the athlete is 100% symptom free, they will progress through the Return to Play protocol.
- ☐ **Step 3.** Follow the Return to Play Protocol instructions.
  - ➢ The athlete's parent/guardian will monitor the athlete's progress through the return to play protocol.
- ☐ **Step 4.** Obtain final clearance signature from Q.H.C.P.
- ☐ **Step 5.** Return all completed and signed paperwork to necessary administration to remove player restriction.
  - ➢ Athletes CANNOT return to sport/activity until ALL paperwork is completed, signed, and returned to the Q.H.C.P.
  - ➢ The Q.H.C.P. monitoring the athlete's progress will return the Concussion Clearance Form to the appropriate administrative staff.
  - ➢ Athletes will not be able to fully return to play until this document is received and cleared with administration.

Your child has sustained a head injury and by policy has been removed from play until he/she has been medically cleared to return to play by a qualified health care professional. The following have been adapted from guidelines published by the National Athletic Trainer's Association and are listed to serve as guidelines only for management during the initial 24 hours following injury:

It is **OK** to:

- Use acetaminophen (Tylenol) for headaches
- Use an ice pack on head and neck as needed for comfort
- Eat a carbohydrate-rich diet
- Get appropriate sleep (8-10 Hrs.)
- Rest, as needed (no strenuous activity or sports)
- Begin light physical activities as tolerated

There is NO need to:

- Check eyes with a flashlight
- Wake up frequently
- Test reflexes
- Stay in bed

Do **NOT**:

- Drink alcohol
- Drive a car or operate machinery
- Engage in physical activity that makes symptoms worse
- Engage in mental activity that makes symptoms worse

Do monitor for significant changes in condition over the next 24 hours. Immediately obtain emergency care for any of the following signs or symptoms:

- Vomiting
- Unequal pupil size
- Difficulty in being aroused
- Clear or bloody drainage from ear or nose
- Continuing or worsening headache
- Seizures
- Slurred speech or inability to speak
- Increasing confusion
- Weakness or numbness in arms or legs
- Unusual behavior change – increasing irritability
- Loss of consciousness

Improvement

- The best indication that an athlete who has suffered a head injury is positively progressing, is that he/she is alert and behaving normally.

Contact your qualified health care provider (Q.H.C.P.) for evaluation before returning to physical activities. The athlete must fully complete the Return to Play Protocol Requirements before he/she is allowed to return to play.

Return to Play Protocol Requirements

- The R.T.P.P. was designed as a safe, gradual return to sport protocol ensuring that an increase in activity level does not cause a reoccurrence of symptoms.
- It is expected that each athlete will start in stage 1 and remain in stage 1 until they are able to complete the stage relatively symptom free.
- There must be a **24-hour window** between each successfully completed stage, before the next state is attempted.
- If symptoms occur during any stage, then stop activity. That stage may be attempted again in 24 hours.
- It is recommended that if a single stage cannot be passed symptom free within 2 attempts then the athlete should return to the Qualified Health Care Provider and report symptoms.
- A player's parent(s) or legal guardian(s) shall be responsible for overseeing the completion of the R.T.P.P.
- Parents/legal guardians may seek assistance for the R.T.P.P., but liability for an accurate and completed protocol will reside with the parents/legal guardians.

Once the protocol has been completed and athlete has received the *final signature* from the Qualified Health Care Provider *(page2)*, this information must be emailed or delivered to the appropriate administration *(Appropriate Administration is defined in the UYSA Concussion Policy).*

- If the athlete's head injury occurred during a **UYSA hosted event**, then the completed clearance form must be emailed directly to the UYSA office to remove their injury restriction. A UYSA hosted event is defined as:
    - State Cup (Spring and Fall events)
    - Presidents Cup
    - All State Select/ODP Events

- If the injury occurred during a **UYSA non-hosted event**, then the completed clearance form must be emailed to the hosting club's administration. A UYSA non-hosted event may include but is not limited to the proceeding events:
    - Regular season play
    - Practices, scrimmages, tryouts, and camps
    - Club hosted events and tournaments

Qualified Health Care Provider Statement

I _____, am a Qualified Health Care Provider as specified in the Utah Youth Soccer Association Concussion Management Policy (M.D., Ph.D., A.T.C., N.P., P.A.). I am trained in the management, evaluation, and treatment of a concussion and:

- Licensed under Utah Code, Title 58, and Division of Occupational and Professional Licensing.
- Can evaluate and manage a concussion within the scope of my practice.
- Within **3 years** have successfully completed a continuing education course in the evaluation and management of concussions.

_____ _____

(Qualification (M.D., PhD, A.T.C., N.P., P.A.) *Utah License Number (optional)*

_____ ____ /____ /_____ (_____)_____-_____

Signature Date Date Phone Number

CONCUSSION RETURN TO PLAY PROTOCOL

Stage	Functional Exercise or Activity
1. Activities of daily living (ADLs)	**Symptom-limited activities of daily living - Gradual reintroduction of schoolwork** *OBJECTIVE: 48-72 hours of Rest and recovery, avoidance of overexertion.*
Date Tested	o **Typical activities of daily living that do not increase symptoms more than 1-2 points and these symptoms resolve quickly with stopping (~1 hour) (Post-Concussion Symptom Scale: Weekly Tracking Form)**
Notes **Date Cleared: _____** **Initials: _____**	
2. Light Aerobic Physical Activity (<70% effort)	**Non-impact aerobic activity (NON-CONTACT):** *OBJECTIVE: Increase heart rate, maintain condition, and assess tolerance of activity.*
Date Tested	o **10 minutes on stationary bike with HR <135 (Symptoms do not increase more than 1-2 points and resolve quickly with stopping (~1 hour) (Post-Concussion Symptom Scale: Weekly Tracking Form)**
Notes **Date Cleared: _____** **Initials: _____**	
3. Moderate Aerobic Physical Activity (70-85% effort)	**Moderate aerobic intensity (NON-CONTACT):** *OBJECTIVE: Begin moderate aerobic activity; introduce soccer specific drills, No symptom increase. If symptoms do increase, then repeat back to Stage 1 or 2.*
Date Tested	o **10 minutes on stationary bike with HR <150** o **10 min jog** o **6 x 40 yd. sprints (3-50% and 3-75%)** o **2 x 40 yd. sprint (full speed)** o **Incorporate easy to moderate resistance training** o **1:1 technical training with the ball** o **Passing and easy shooting on targets** o **Core work: easy to moderate exercises**
Notes **Date Cleared: _____** **Initials: _____**	
4. Non-Contact Training Drills (100% effort)	**Training drills (NON-CONTACT):** *OBJECTIVE: Ensure tolerance of all activities short of physical contact. No symptom increase. If symptoms do increase, then repeat back to Stage 1 or 2.*
Date Tested	o **Small group training** o **Increase from small field to full field** o **Shots on goal** o **Continue aerobic training** o **Continue resistance training**
Notes **Date Cleared: _____** **Initials: _____**	
5. Full Contact Practice (100% effort)	**Increasing contact is allowed:** *OBJECTIVE: Assess physical, cognitive and psychological readiness. No symptoms that are not typically experienced prior to injury.*
Date Tested	o **Controlled contact and increasing workload to prepare for game situation**
Notes **Date Cleared: _____** **Initials: _____**	
6. Return to Play	**Regular game competition** *OBJECTIVE: Return to Competitive Competition/Practices. No symptoms that are not typically experienced prior to injury.*
Date Tested	o **Release to Full Contact Activity**
Notes **Date Cleared: _____** **Initials: _____**	

Post-Concussion Symptom Scale: Week Tracking Form

Instructions: For each item indicate how much the symptom has bothered you *today.*

Severity Rating

None	Mild	Moderate	Severe
0	1 – 2	3 – 4	5 – 6

Symptoms	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Headache							
"Pressure in head"							
Neck Pain							
Nausea or Vomiting							
Dizziness							
Blurred Vision							
Balance Problems							
Sensitivity to Light							
Sensitivity to Noise							
Feeling Slowed Down							
Feeling like "in a fog"							
"Don't feel right"							
Difficulty Concentrating							
Difficulty Remembering							
Fatigue or Low Energy							
Confusion							
Drowsiness							
Feeling more Emotional							
Irritability							
Sadness							
Nervous or Anxious							
Trouble Falling Asleep							

Pain other than Headache: (please specify location): _____

Do your symptoms get worse with physical activity: ☐ No ☐ Yes (please describe) _____

_____

Do your symptoms get worse with mental activity: ☐ No ☐ Yes (please describe) _____

_____

Return to Academics Recommendations After Concussion/Mild TBI

***Not all students will need academic accommodations following a concussion. Please consult the athlete's healthcare provider if accommodations are recommended.**

In the early stages of recovery after a concussion, increased cognitive demands, such as academic coursework, as well as physical demands may worsen symptoms and prolong recovery. Accordingly, a comprehensive concussion management plan will provide appropriate provisions for adjustment of academic coursework on a case by case basis.

Please ensure that teacher(s) and administrator(s) are aware of your injury and symptoms. School personnel should be instructed to watch for:

- Increased problems with paying attention, concentrating, remembering, or learning new information
- Longer time needed to complete tasks or assignments
- Greater irritability, less able to cope with stress
- Symptoms worsen (e.g., headache, tiredness, etc.) when doing schoolwork

Until fully recovered, the following support and/or modifications are recommended: (mark all that apply)

__ May return immediately to school full time (date) _____
__ No to return to school. May return on (date) _____
__ Return to school with supports as checked below. Review on (date) _____

- __ Shortened day. Recommend _____ hours per day until (date) _____
- __ Shortened classes (i.e., rest breaks during classes). Maximum class length: _____ minutes
- __ Allow extra time to complete coursework/assignments and tests.
- __ Reduce homework load by ____ %
- __ Maximum length of nightly homework: ____ minutes
- __ No significant classroom or standardized testing at this time
- __ No more than one test per day
- __ Take rest breaks during the day as needed
- __ Allow the student to leave class a few minutes early to avoid excessive stimulation from noisy hallways
- __ Other: _____

Under no circumstances should a student-athlete be permitted to return to contact activities at practice or competition if they have not successfully reintegrated back to school, or if they are continuing to require extra accommodations in school that were not previously part of a student 504 or IEP plan.

Additional Notes or Recommendations:

_____
_____
_____

_____ _____ ___/___/___
Health Professional (print name) *Health Professional (signature)* *Date*

Phone*:* (_____) _____ -_____ Email*:* _____
Health Professional Phone Number *Health Professional Email*

CONCUSSION DIAGNOSIS FORM

For the USE and RECORD of the Q.H.C.P. making the initial diagnosis
(Please tear this sheet from the packet and keep for your personal records)

Athlete Information

_____ _____/_____/_____ U-_____ _____
Athlete's Name *Date of Birth* *Club Name / Event*

_____/_____/_____ _____/_____/_____ _____ AM PM
Date of Injury *Date of Initial Exam* *Time of Initial Exam*

Parent/Guardian Release

The athlete will be released to, _____ who is an adult over the age of 18, and is capable of monitoring the above named athlete's medical condition. If the above-named adult is not the parent/legal guardian of the above-named athlete, then they are responsible for monitoring the named athlete's progress until a parent/legal guardian is present, or until athlete is under the care of a medical professional. If the individual's symptoms worsen then immediate medical attention is needed.

☐ Called and spoke with parent/guardian ☐ Emailed parent/guardian ☐ Other: _____

Phone: (_____) _____ -_____ Email: _____ Date: _____

SIGNS AND SYMPTOMS

__ **SCAT 5** Performed and included with athlete injury documentation

__ Headache	__ Nausea	__ Vomiting	__ Balance Problems
__ Dizziness	__ Visual Problems	__ Fatigue	__ Sensitivity to Light
__ Sensitivity to Noise	__ Numbness/Tingling	__ Mentally Foggy	__ Slowed Down
__ Difficulty Concentrating	__ Difficulty Remembering	__ Drowsiness	__ Sleeping Less than Usual
__ Sleeping more than Usual	__ Trouble Falling Asleep	__ Irritability	__ Sadness
__ Nervous	__ Feeling more Emotional	__ "Pressure in Head"	__ Neck Pain
__ "Don't Feel Right"	__ Other: _____		

Notes:

_____

_____

_____

_____

_____

_____

_____ ____/____/_____
Health Professional Signature *Date*