Form 314-2

CONCUSSION - RETURN TO LEARN / RETURN TO PHYSICAL ACTIVITY PLAN

This form, to be used by parents/guardians and the School Administrator(s), is a combined approach with collaborative effort between the home and school, used to communicate the student's progress through the plan AFTER being diagnosed with a concussion.

- **Return to Learn Step 2a must be completed prior to the student returning to physical activity.**
- **Each step must take a minimum of 24 hours. *Note:* *Step 2 and 2b can occur concurrently.***
- **All steps must be followed.**

Return to Learn / Return to Physical Activity - Step 1 (must be completed prior to Step 2a)

- Completed at home
- Cognitive Rest – includes limiting activities that require concentration and attention (ex, reading, texting, television, computer, video/electronic games)
- Physical Rest – includes restricting recreational/leisure and competitive physical activities

☐ My child/ward has completed **Step 1** of the *Return to Learn / Return to Physical Activity Plan* (cognitive and physical rest at home) and his/her symptoms have shown improvement. My child/ward is ready to proceed to **Return to Learn – Step 2a**.

☐ My child/ward has completed **Step 1** of the *Return to Learn / Return to Physical Activity Plan* (cognitive and physical rest at home) and is symptom free. My child/ward is ready to proceed directly to **Return to Learn – Step 2b** and **Return to Physical Activity – Step 2**.

Parent/Guardian Signature: _____ Date (M/D/Y): _____

Parent/Guardian Name (Print): _____

Comments: _____

School Administrator(s) Signature: _____ Print: _____

Return of Symptoms

☐ My child/ward has experienced a return of concussion signs and/or symptoms and has been examined by a medical professional, who has advised a return to:

Return to Learn / Return to Physical Activity – Step _____ of the Plan.

Parent/Guardian Signature: _____ Date (M/D/Y): _____

Parent/Guardian Name (Print): _____

Comments: _____

If at any time during the following steps symptoms return, please refer to the "Return of Symptoms" section on Page 1.

Return to Learn – Step 2a

- Student returns to school
- Student requires individualized classroom strategies and/or approaches which gradually increase cognitive activity
- Physical rest – includes restricting recreational/leisure and competitive physical activities

☐ My child/ward has been receiving individualized classroom strategies and/or approaches and is symptom free. My child/ward is ready to proceed directly to **Return to Learn – Step 2b** and ***Return to Physical Activity* – Step 2**.

Parent/Guardian Signature: _____ Date (M/D/Y): _____

Parent/Guardian Name (Print): _____

Comments: _____

Return to Learn – Step 2b

- Student returns to regular learning activities at the school

Return to Physical Activity – Step 2

- Student can participate in individual light aerobic physical activity only
- Student continues with regular learning activities

☐ My child/ward is symptom free after participating in light aerobic physical activity. My child/ward is ready to proceed to **Return to Physical Activity – Step 3**.

Parent/Guardian Signature: _____ Date (M/D/Y): _____

Parent/Guardian Name (Print): _____

Comments: _____

If at any time during the following steps symptoms return, please refer to the "Return of Symptoms" section on page 1.

Return to Physical Activity – Step 3

- Student may begin individual sport-specific physical activity only

Return to Physical Activity – Step 4

- Student may begin activities where there is no body contact (ex, dance, badminton); light resistance/weight training; non-contact practice; and non-contact sport-specific drills

☐ Student has successfully completed **Steps 3 and 4** and is symptom free.

☐ This form has been returned by the School Administrator(s) to the parent/guardian to obtain medical professional diagnosis and signature.

Medical Examination

☐ I, _____ (medical professional name) have examined _____ (student name) and confirm he/she continues to be symptom free and is able to return to regular physical education class/intramural activities/ interschool activities in non-contact sports and full training/practices for contact sports.

Signature of Medical Professional: _____ Date (M/D/Y): _____

Comments: _____

_____

This form, with medical professional signature, is to be returned to the School Administrator(s) before the student may proceed to Step 5.

If at any time during the following steps symptoms return, please refer to the "Return of Symptoms" section on page 1.

Return to Physical Activity – Step 5

- Student may resume regular physical education/intramural activities/interschool activities in non-contact sports and full training/practices for contact sports

This form is to be returned to the parent/guardian for final signature:

☐ My child/ward is symptom free after participating in activities, in practice, where there is body contact and has my permission to participate fully, including participation in competition.

Parent/Guardian Signature: _____ Date (M/D/Y): _____

Parent/Guardian Name (Print): _____

Comments: _____

Return to Physical Activity – Step 6

- The student may resume full participation in contact sports with no restrictions