Mercer Island High School
Concussion Return-to-Play Protocol Form

Athletic Trainer Evaluation

Patient’s Name: __________________________ Date of Concussion: ___________________

How Concussion Occurred: ___________________________________________________________

Athletic Trainer Signature: __________________________ Date: ___________________

Symptoms:

- Headache  
- Dizziness  
- Confusion  
- Personality Changes  
- Pressure in Head  
- Neck Pain  
- Vision Problems  
- Sensitivity to Light/Noise  
- Concentration/Memory Problems  
- Recall Problems prior/post event  
- Nausea  
- Drowsiness  
-Feels Foggy/Sluggish  
-Balance Problems  
- Other: __________________________

Assessments Performed:

- Orientation  
- Immediate Memory  
- Delayed Memory  
- Concentration  
- Coordination  
- Balance  
- PERRLA  
- Cranial Nerve Assessment  

Please take this form to your doctor’s appointment to be filled out. This form must be completed and returned to the Athletic Trainer or faxed to (206) 230-6316 before the athlete can start the return-to-play protocol. This form is not for general injury clearance; see the “Athletic Injury Return-to-Play” form.

Date of doctor visit: __________________________

Symptoms at time of visit:

- Headache  
- Dizziness  
- Confusion  
- Personality Changes  
- Pressure in Head  
- Neck Pain  
- Vision Problems  
- Sensitivity to Light/Noise  
- Concentration/Memory Problems  
- Recall Problems prior/post event  
- Nausea  
- Drowsiness  
- Feels Foggy/Sluggish  
- Balance Problems  
- Other: __________________________

I. ______ Patient is ready to start the monitored return-to-play protocol as of ______________________ (date)
   Each step is separated by 24 hours; back up one day if any symptoms return.
   - No activity and rest until asymptomatic
   - Light aerobic exercise
   - Sport-specific exercise
   - Noncontact drills
   - Full-contact drills
   - Game play

II. ______ Patient is not cleared to start monitored return-to-play protocol and will be seen by treating doctor again on ______________________ (date)

III. ______ Patient is being referred for further testing/evaluation to: __________________________
   on ______________________ (date)

Physician’s Signature: __________________________ Date: __________________________

Physician’s Name: __________________________ Phone: __________________________

Place additional comments on reverse of sheet  Updated 6/14/2012