ATHLETIC TRAINING

PHYSICIAN CONCUSSION FORM

Student Name:	**DOB:**
INJURY STATUS	**Date of Concussion Diagnosis by MD/DO:** _____ **Date of Injury:** _____

☐ Student has been diagnosed by a MD/DO with a concussion and is currently under our care.
Medical follow-up evaluation is scheduled for (Date): _____

☐ Student was evaluated and did not have a concussion injury. There are no limitations on school and physical activity.

PHYSICAL ACTIVITY STATUS (Please mark all that apply)

☐ **This student is not to participate in physical activity of any kind.**

☐ This student is not to participate in PE or other physical activities except for untimed, voluntary walking.

☐ This student may begin a graduated return to play progression (Concussion RTP Protocol form)
Date student may begin RTP protocol _____

☐ This student has medical clearance for unrestricted athletic participation (Has completed the Concussion RTP Protocol)

Physician (MD/DO) Signature: _____ **Date of Exam: _____**

Physician Stamp and Contact Info:

Parent/Guardian Acknowledgement Signature:_____ **Date: _____**

Student Name:_____ **Date of Injury:_____** **Date of Concussion Diagnosis: _____**

- **Without a specific start date for the Return to Play (RTP) Protocol established by the diagnosing physician, the AMHS Athletic Training Staff will follow the AMHS RTP protocol in accordance with CIF Bylaws.**

AMHS Athletic Training
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