Skyline High School

Medical Referral for Concussed Athlete

Name: _____ Age:_____ Grade: _____

Date of Concussion: _____ Sport: _____ Level: ☐Var ☐JV ☐C

Concussion History: Date(s) of previous concussion_____

Mechanism of Injury: _____

_____

Treatment by Athletic Trainer:

☐ Removed from participation ☐ SCAT3 ☐ Neuro Exam

☐ VOMS (Vestibular Ocular-Motor Screen) ☐ Referral to ER

Athletic Trainer: _____ **Phone:** 425-837-7896

Dear Physician,

Please review and fill out this form and have the athlete return it to his/her athletic trainer.

This form is to notify you of Skyline High School's concussion management protocols and to ensure the athlete returns to school and sports safely and at the appropriate time. Please contact me if you have any questions (phone number above).

Skyline Return to Play Steps: (only 1 stage/24 hours; if symptoms occur, stop and retry step the following day.)

STAGE	FUNCTIONAL EXERCISE	OBJECTIVE
1. No activity	Physical and mental rest. May need to be excused from school if recommended by physician and athletic trainer.	Recovery
2. Light aerobic exercise	Walking, light swimming, stationary bike, heart rate <70% maximum	Increase heart rate
3. Sport specific exercise	Jogging, running drills without contact, push-ups, sit-ups, jumping jacks	Add movement
4. Non-contact drills	More complex training drills, may start resistance training	Exercise, coordination, and cognitive load
5. Full contact practice	Full practice	Restore confidence
6. Return to Play	Game play	

Please indicate Level of Clearance (To be filled out by Physician)

_____ Cognitive and Physical Rest; Limit School attendance, computer, TV, phone & texting.
_____ Cleared to Return to School with NO physical activity, including NO physical education or athletics
_____ Follow-up appointment scheduled
_____ Cleared to begin Return to Activity (Stages 2-6 above)

Physician's Name: _____ Phone: _____

Physician's Signature: _____ Date: _____