**MEDICAL CONCUSSION CLEARANCE**

**Required before return to full contact training or play.**

Name:

DOB:   /  /

Sport/Club:

Date of concussion:   /  /

Days since concussion:

Concussion sustained at: Match  Training  Other

Any loss of consciousness? No  Yes

If Yes, how long?

Did you go to Hospital? No  Yes

If Yes, did you have any scans? No  Yes

If Yes, results

If Yes, were you admitted? No  Yes

If Yes, for how long

Did you have a SCAT 5 assessment? No  Yes

If Yes, by a: Doctor  Physio  Trainer  (attach copies of SCAT/s if possible)

If Yes: Symptom number       Symptom score

How many days until you were symptom free? 1  2  3  4  5 or more

Did you miss any school or work? No  Yes

If yes, how many days?

Have you had a concussion before? No  Yes

If yes, please list dates of previous concussions:

**RETURN TO SPORT**

Light/Moderate session Date:   /  /     Symptoms: No  Yes

Sports Specific Moderate Date:   /  /     Symptoms: No  Yes

Limited contact training Date:   /  /     Symptoms: No  Yes

Planned full contact return Date:   /  /     Symptoms: No  Yes

**DOCTOR SUMMARY**

Date of last symptoms:   /  /

Any residual symptoms?

Has completed each graduated stage of return to training without any symptoms:

No  Yes

Patient considers fully recovered:

No  Yes

Clear to return to full train/play?

No  Yes

If no, reasons to withhold clearance

Physician/Doctor Name:

Qualifications:

Date:   /  /