

# Concussion Management – Return to Play Protocol Form

*(This form would be completed following a concussion injury)*

*This form must be submitted to the Principal who is responsible for compliance with the **Return to Play Protocol** approved by the School Board of Management.*

**Student Name (Please Print):**

**Class:**

## **The Principal verifies:**

- Has completed the mandatory 2 week rest period
- The student has been evaluated by a treating physician selected by the student, their parent or other person with legal authority to make medical decisions for the student
- The student has completed the Return to Play Protocol approved by the Board of Management
- The school has received a written statement from the treating physician indicating, that in the physician's professional judgment, it is safe for the student to return to play.

*School Principal's Signature:*

*Date:*

**The parent/guardian or other person with legal authority to make medical decisions for the student signs and certifies that he/she:**

- Has completed the mandatory 2 week rest period
- Has confirmed that the student has been evaluated by a treating physician and that in the treating physician's professional judgment it is safe for the student to return to play
- Has been informed concerning and consents to the student participating in returning to play in accordance with the Return to Play Protocol established by the Board of Management
- Understands the risks associated with the student returning to play and will comply with any ongoing requirements in the Return to Play Protocol.

*Parent/guardian signature:*

*Date*

*Parent/guardian name (Please Print):*