PROVIDENCE
Sports Medicine

PLAYER NAME: _____ **DATE OF INJURY:** _____

Post-Concussion Graduated Return to Play Protocol

MUST HAVE MEDICAL CLEARANCE TO BEGIN PROTOCOL

STEP 1 LIMITED ACTIVITY	STEP 2 LIGHT AEROBIC EXERCISE	STEP 3 SPORT SPECIFIC EXERCISE	STEP 4* NON-CONTACT TRAINING DRILLS	STEP 5 FULL CONTACT PRACTICE
RECOVERY Resumption of everyday activities as tolerated Able to do limited activity, i.e. walking if feeling well	**INCREASE HEART RATE** Walking, swimming, stationary bicycle **Heart Rate <70% - 15 min.**	**ADD MOVEMENT** Running drills, dribbling, etc. **NO head impact activities** **Heart Rate <80% - 45 min.**	**INCREASED EXERCISE, COORDINATION & ATTENTION** Progress to complex training drills (e.g., passing drills, etc.) May start resistance training **Heart Rate <90% - 60 min.**	**RESTORE CONFIDENCE & ASSESS FUNCTIONAL SKILLS** If symptom free, return to normal training activities
Symptom free for 24 hours? **YES:** Begin Step 2 **NO:** Continue Resting	**Symptom free for 24 hours?** **YES:** Move to Step 3 **NO:** Rest further until symptom free	**Symptom free for 24 hours?** **YES:** Move to Step 4 **NO:** Return to Step 2 until symptom free	**Symptom free for 24 hours?** **YES:** Move to Step 5 **NO:** Return to Step 3 until symptom free	**Symptom free for 24 hours?** **YES:** Return to play **NO:** Return to Step 4 until symptom free
Date: _____ **Parent initial:** _____	**Date:** _____ **Parent initial:** _____	**Date:** _____ **Parent initial:** _____	**Date:** _____ **Parent initial:** _____	**Date:** _____ **Parent initial:** _____

*Law requires ages 18 and under to be cleared by a qualified healthcare professional

Heart Rate: % heart rate is determined by taking the % of maximum heart rate. Maximum heart rate is determined by the following formula: 220 – Athlete's Age = Max Heart Rate.

As Parent/Guardian of the above named player I acknowledge that he/she has completed these steps on the dates I have initialed above. I understand that I must obtain final clearance from a medical professional before the player can return to play.

_____ _____ _____

PARENT/GUARDIAN (print name) SIGNATURE DATE

The above named player has completed the appropriate steps to return to physical activity after his/her concussion. He/she is now cleared to fully participate in sports and PE.

_____ _____ _____

DOCTOR/MEDICAL PROFESSIONAL (print name) SIGNATURE DATE

_____ ( ) _____

DOCTOR/MEDICAL PROFESSIONAL TITLE PHONE