MARYLAND STATE DEPARTMENT OF EDUCATION
EQUITY AND EXCELLENCE

Name of Athlete _____
Sport/season _____
Date Received _____

Medical Clearance for Student-Athlete Suspected Head Injury

Section 1: Initial Observation to be completed by Coach, Athletic Trainer and/or First Responder

Athlete's Name _____ DOB _____ School _____ Sport _____

Following the injury, did the athlete experience:	Circle One	Symptoms	Comments
Loss of consciousness or unresponsiveness	Yes / No		
Seizure or convulsive activity	Yes / No		
Balance problems/unsteadiness	Yes / No		
Dizziness	Yes / No		
Headache	Yes / No		
Nausea/Vomiting	Yes / No		
Emotional Instability (abnormal laughing, crying, anger)	Yes / No		
Confusion/Easily distracted	Yes / No		
Sensitivity to Light/noise	Yes / No		
Vision problems?	Yes / No		
Neck Pain	Yes / No		

Describe the injury, or give additional details: _____

Injury History: Name of Person Completing Form: _____ Relationship: _____

Date of Injury: _____ Time of Injury: _____ Phone Number: _____

Section 2: To Be Filled Out By a Licensed Heath Care Provider (LHCP)

Medical Provider Recommendations According to COMAR 13A.06.08.01, only licensed health care providers (LHCP) ***trained in the evaluation and management of concussions*** are permitted to authorize a student athlete to return to play

*This return to play (RTP) plan is based on today's evaluation

LHCP Diagnosis:

- ☐ No Concussion - May Return to Full Academic and Physical Activity
- ☐ Concussion

*** PLEASE NOTE THESE REQUIREMENTS TO RETURN TO SPORTS PLEASE COMPLETE***	1. Athletes are not allowed to return to practice or play the same day that their head injury occurred 2. Athletes should never return to play or practice if they still have **ANY SYMPTOMS** 3. Athletes, be sure that your coach and/or athletic trainer are aware of your injury, symptoms, and has the contact information for the treating physician
SCHOOL (ACADEMICS) **COMPLETED BY LHCP**	☐ May return to school now ☐ May return to school on ____/____/____ ☐ Out of school until follow up (F/u is scheduled for _____) ☐ Limitations or Accommodations (please see below or attached)
SPORTS/PHYSICAL ACTIVITIES	☐ May start return to play progression under the supervision of the health care provider for your school/team ☐ Must return to medical provider for final clearance to return to competition and physical activities

Additional Comments/Instructions: _____

LHCP Name: _____

Signature: _____

Date: _____ Phone Number: _____

I certify that I am aware of the current medical guidance on concussion evaluation and management.

Office Stamp:

- *All Maryland public school athletes must have a Licensed Health Care Providers signature to return to play*
- *More than one evaluation is typically necessary for medical clearance for concussion, as symptoms may not fully present for days.*

RETURN COMPLETED FORM TO SCHOOL NURSE, ATHLETIC DIRECTOR, AND ATHLETIC TRAINER