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 of 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 Health 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<br>2. Athletes should never return to play or practice if they still have **ANY SYMPTOMS**<br>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<br>☐ May return to school ___ / _____ / _____<br>☐ Out of school until follow up (follow up is scheduled for ____ )<br>☐ 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<br>☐ Must return to medical provider for final clearance to return 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**