AIM ATHLETIC TRAINING

# PHYSICIAN CONCUSSION FORM

| Student Name: | DOB: |
|---|---|
| **INJURY STATUS** | **Date of Concussion Diagnosis by MD/DO:** _____<br>**Date of Injury:** _____ |

☐ Student has been diagnosed by a MD/DO with a concussion and is currently under our care.

**Medical follow-up evaluation is scheduled for (Date): _____**

☐ Student was evaluated and did not have a concussion injury. There are no limitations on school and physical activity.

**PHYSICAL ACTIVITY STATUS (Please mark all that apply)**

☐ **This student is not to participate in physical activity of any kind.**

☐ This student is not to participate in PE or other physical activities except for untimed, voluntary walking.

☐ This student may begin a graduated return to play progression (Concussion RTP Protocol form)

**Date student may begin RTP protocol _____**

☐ This student has medical clearance for unrestricted athletic participation (Has completed the Concussion RTP Protocol)

**Physician (MD/DO) Signature: _____** **Date of Exam: _____**

**Physician Stamp and Contact Info:**

**Parent/Guardian Acknowledgement Signature:_____** **Date: _____**

**Student Name:_____** **Date of Injury:_____** **Date of Concussion Diagnosis: _____**

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