CONCUSSION ACTION PLAN

We suspect your child, _____________________________ may have sustained a concussion during athletic activity today. At ______________ (time and date) he/she was exhibiting the following symptoms:

- Headache
- Nausea
- Dizziness
- Confusion
- Irritability
- Mood Changes
- Felt Tired
- Sound Sensitivity
- Amnesia
- Balance Changes
- Ears Ringing
- Clumsy Movement
- Light Sensitivity
- Other ___________________________

We removed your child from participation in activity for the remainder of the day. Prior to him/her returning to activity with our organization, one of the following must be completed:

☐ Written note from an Appropriate Healthcare Provider stating the child may return to activity without restrictions.

Your child’s safety is of the utmost importance to us. We thank you for your cooperation in ensuring that our concerns of a possible concussion are attended to.

_________________________ Coach’s printed name

_________________________ Coach’s Signature

To be completed by appropriate healthcare provider only:

Concussion assessment completed for ___________________________. The following recommendations are made:

☐ No participation until further evaluation completed. Recommend complete “brain rest” from all physical activity, including weight lifting.

☐ Return to activity without restrictions. Patient has completed progressive physical activity program.

☐ Other ___________________________

_________________________ Physician/AHCP name

_________________________ Signature/Date

Progressive Physical Activity Program in day progressions
1. Light aerobic exercise, 5–10 minutes on exercise bike or light jog; no weight lifting, resistance training or any other exercise.
2. Moderate aerobic exercise – 15 minutes of running at moderate intensity, without equipment.
3. Non-contact training drills in full uniform. May begin weight lifting, resistance training and other exercise.
4. Full Contact Practice or training.
5. Full game play.

*Zurich Concussion Statement 2008