Return completed form to ASA – medical@azyouthsoccer.org

ASA CONCUSSION RETURN TO PLAY - PHYSICIAN FORM

INITIAL PHYSICIAN EVALUATION FORM (PLEASE PRINT):

STUDENT NAME:	
DATE OF BIRTH:	
DATE OF INJURY:	
DATE OF EVALUATION	
SOCCER CLUB/TEAM:	
SCHOOL/GRADE:	

_____Through my evaluation, I have found that the athlete named above **HAS NOT** suffered a concussion and is medically returned to play on: _____/_____/_____.

____Through my evaluation, I have found that the athlete named above **HAS** suffered a concussion and is not able to return to activity until cleared by a physician.

_____/_____/_____ _____
Follow-up Appointment Date: Physician's Name (Please Print):

The ASA "Return to Play" form must be completed and signed by a licensed Medical Doctor (MD) or Doctor of Osteopathy (DO) per ASA Head Injury/Concussion Policy

At this time, the student is:

☐ Symptom-free at rest ☐ **NOT** symptom-free at rest

☐ Symptom-free with exertion ☐ **NOT** symptom-free with exertion

_____ _____ _____ _____/_____/_____
Physician Name (Print) Physician Signature Degree/Specialty Date

_____ _____
Physician Office Phone Number Physician Office Fax Number

ASA CONCUSSION RETURN TO PLAY - PHYSICIAN FOLLOW-UP FORM

FOLLOW-UP PHYSICIAN EVALUATION(S) FORM (PLEASE PRINT):

STUDENT NAME:	
DATE OF BIRTH:	
DATE OF INJURY:	
DATE OF EVALUATION	
SOCCER CLUB/TEAM:	
SCHOOL/GRADE:	

I have evaluated the above named athlete and my medical opinion is that he/she:

_____ is **NOT** cleared to and will be seen in follow-up appointment on: _____/_____/_____

_____ may return to activity on _____/_____/_____ and should follow the Return to Play Progression and should remain symptom free through each step.

_____ may return to play on _____/_____/_____ is cleared to return to full activity due to the fact that they have had a complete neurological exam & neurocognitive testing** which indicates complete recovery and has completed a gradual return to play progression.

(***Neurocognitive testing is not mandatory at this time, but is strongly encouraged by ASA to indicate a complete recovery. Especially in cases where a baseline test has been completed.)*

At this time, the student is:

☐ Symptom-free at rest ☐ **NOT** symptom-free at rest

☐ Symptom-free with exertion ☐ **NOT** symptom-free with exertion

_____	_____	_____	_____/_____/_____
Physician Name (Print)	Physician Signature	Degree/Specialty	Date

_____ _____

Physician Office Phone Number Physician Office Fax Number

CONCUSSION RETURN TO PLAY PROGRESSION

B-R-A-I-N GUIDELINES

B – Bike

- Light Aerobic Activity Phase - Goal is to increase your heartrate - 10-20 minutes in duration

R – Run

- Moderate Aerobic Activity Phase - Goal is to return to a base level of fitness - Running or jogging for 20-30 minutes

A – AGILITY

- Sport Specific Activity - Goal is to return to soccer skills - Work on passing, shooting, footwork with a ball on a soccer field - Max 60 minutes of activity

I - In Another Color

- Non-Contact Return to Practice - Goal is to return to a team setting without entering contact activity - Allow for re-acclimation to being around others - Can be done in practice setting or with other athletes that understand restrictions - Important for the all members of the team understand players limitations

N – No Restrictions

- Goal is full return to practice with a medical clearance from a physician - Full return should be first done in a practice not a game

Note: This form is to be used as a general guideline for return to soccer. There should be a 24 hour period between each stage in which the athlete does not have an increase in symptoms. If symptoms reoccur or increase, there should not be advancement to the next stage. This progression should be monitored by a medical professional, coach or parent.