

Post-Concussion: Return to Play Progress Questionnaire

To be completed by non-medical personnel (e.g., coaches, PE teachers, health technicians, special-ed health technicians) to document a student's daily progress towards "Return to Play"

Student's Name:	Date:
School staff member completing form:	(name); (job title)
Today this student participated in the following level of activity (as defined on district or CIF "Return to Play" form): check one □ Stage 1 (Limited Physical Activity); □ Stage 2 (Light aerobic activity); □ Stage 3 (Moderate aerobic and/or light resistance training); □ Stage 4 (Strenuous aerobic activity and/or moderate resistance training) □ Stage 5 (Non-contact training; Sport-specific drills; Need MD note and no symptoms to progress further than this step)	
☐ Stage 6 (Limited practice only for contact sports; Unrestricted practice for non-contact sports) ☐ Stage 7 (Full contact practice / Full unrestricted practice) ☐ Stage 8 (Competition/Full game play/No restrictions) Note: need to have had one contact practice before entering this final stage of competition.	
After this activity, I inquired, and the student reported the following (check all that apply): □ Confusion or foggy feeling □ Nausea or vomiting □ Dizziness or seeing stars □ Ringing in ears	
☐ Developed a headache ☐ Slurred speech ☐ Delayed response to questions ☐ Light sensitive	
☐ Noise sensitive ☐ More fatigue than expected ☐ Irritability or personality change	
□ No symptoms at all	
Were any of the above (checked) symptoms new? Or if not new, did the physical activity make it worse? ☐ Yes ☐ No In responding to this, the student appeared to be truthful to me:	
	nent:]
Signature of staff member	Date
Completed forms are to be shared with school nurse (and athletic trainer, if an athlete). File form in the school site health office;	
The school nurse may share this information with physician who is co-managing the student's post-concussion, "Return to Play" plan.	