UTAH YOUTH SOCCER ASSOCIATION
CONCUSSION CLEARANCE FORM

Utah Youth Soccer Association (UYSA) has developed this form as a uniform method for Qualified Health Care Providers (Q.H.C.P.) to present a written release for athletes to return to play after having sustained a concussion, or have been removed from participation due to demonstrating signs, symptoms, or behaviors consistent with a traumatic brain injury. Final authority for return to play clearance shall reside with a Q.H.C.P. as designated by the Utah *'Protection of Athletes with Head Injuries'* Act (UCA 36-12-13(2)). Prior to returning to competition the concussed athlete shall have a written release signed by a Qualified Health Care Provider indicating the athlete is medically released to return to play. **The use of this form is required for the clearance of all UYSA affiliated athletes.**

An athlete MAY NOT return to play until THIS FORM is signed by a Q.H.C.P. and returned to the appropriate administrative staff as outlined by the UYSA Concussion Policy.

Players Information

_____ _____ U-____ _____

Players Name *Team Name* *Age* *Event (i.e. tournament, season game)*

_____/_____/_____ _____/_____/_____ _____ AM PM _____/_____ /_____

Date of Injury *Date of Initial Exam* *Time of Exam* *Date of Birth*

The athlete will be released to, _____ who is an adult over the age of 18, and is capable of monitoring the above named athletes medical condition. If the above named adult is not the parent/legal guardian of the above named athlete, then they are responsible for monitoring the named athlete's progress until a parent/legal guardian is present, or until athlete is under the care of a medical professional. If the individual's symptoms worsen then immediate medical attention is needed.

_____ _____/_____/_____

Signature of Person Responsible for Monitoring Progress *Date*

"Overview" Returning Back to the Field Process

Checklist: returning a player back to the field

- ☐ **Step 1.** Initial Evaluation from a Qualified Health Care Provider.
  - If an athlete is suspected of having a concussion or is experiencing symptoms of a traumatic brain injury (TBI) then it is important they are immediately evaluated by a Qualified Health Care Provider (M.D., Ph.D., A.T.C., P.A., or N.P.).
  - They will be diagnosed as **having**, or **not having** a concussion.
  - If diagnosed as **not having**, follow the evaluating Qualified Health Care Providers instruction.
  - If diagnosed as **having** a concussion, then proceed to step 2.
- ☐ **Step 2.** Follow up visit with a Qualified Health Care Provider once the athlete is *symptom free*.
  - *After* the athlete is 100% symptom free they will return to a Qualified Health Care Provider for further information.
- ☐ **Step 3.** Follow Qualified Health Care Provider's return to play orders.
  - The Qualified Health Care Provider will choose 1 of 2 options for "return to play". *(page 2)*
- ☐ **Step 4.** *If needed*, obtain final clearance from Qualified Health Care Provider.
  - If Qualified Health Care Provider chooses option #2, then final clearance will be needed.
- ☐ **Step 5.** Return all completed and signed paperwork to appropriate administrative staff.
  - Athletes will not be able to fully return until they are cleared in affinity through UYSA.

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Evaluation

DIAGNOSIS - for the Q.H.C.P. who is providing the initial evaluation.

The above named athlete has been found to HAVE suffered a concussion on the date of injury noted above. (The Q.H.C.P. providing the return to play clearance will choose a clearance option below).

_____ _____ _____ __/__/____

Health Professional (print name) *Health Professional (signature)* *Qualification: (M.D., A.T.C., etc)* *Date*

Phone: (_____)_____ -_____ Email:_____

Health Professional Office Number *Health Professional Email*

LIABILITY STATEMENT - for Q.H.C.P. providing return to play clearance (details below).

QUALIFIED HEALTH CARE PROVIDER STATEMENT

I _____, am a Qualified Health Care Provider as specified in the Utah Youth Soccer Association Concussion Management Policy (M.D., Ph.D., A.T.C., N.P., P.A.). I am trained in the management, evaluation, and treatment of a concussion and:

- Licensed under Utah Code, Title 58, and Division of Occupational and Professional Licensing.
- Can evaluate and manage a concussion within the scope of my practice.
- Within **3 years** have successfully completed a continuing education course in the evaluation and management of concussions.

_____ _____

(Qualification (M.D., PhD, A.T.C., N.P., P.A.) *Utah License Number (optional)*

_____ ___/___/_____ (_____)_____-_____

Signature Date *Date* *Phone Number*

RETURN TO PLAY CLEARANCE

QUALIFIED HEALTH CARE PROVIDER - Clearance Options

(Qualified Health Care Provider - Please choose 1 of the following 2 options)

☐ **Option 1:** Player is released to return back to play with no restrictions as of the following date: ____/____/_____.

* As a Qualified Health Care Provider, It is my professional opinion that the above named athlete does not need to complete the R.T.P.P. (details page 3)

*It is understood that the final signature below is being granted, and the above named athlete is not required to complete the R.T.P.P. (details pg. 3)

*By signing this form I acknowledge that I am releasing the above named athlete to full return to play with no restrictions and providing a final clearance.

_____ ___/___/_____

Health Professional - signature ***Date***

(Final Clearance)

☐ **Option 2:** Player is released to return back to play after successfully completing the Return to Play Protocol (R.T.P.P.) (details page 3)

_____ ___/___/_____

Health Professional - signature ***Date***

(Permission to start R.T.P.P.)

*It is understood that the final signature below will not be granted until the athlete has completed the R.T.P.P. and has returned back to me (Q.H.C.P.) for a follow up visit.

*By signing this form I acknowledge that the above named athlete has successfully completed the R.T.P.P. and release to play with no restrictions. I am providing final clearance.

_____ ___/___/_____

Health Professional - signature ***Date***

(Final Clearance)

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Return to Play Protocol Requirements

- The R.T.P.P. was designed as a safe, gradual return to sport protocol ensuring that an increase in activity level does not cause a reoccurrence of symptoms.
- It is expected that each athlete will start in stage 1 and remain in stage 1 until they are able to complete the stage symptom free.
- There must be a 24 hour window between each successfully completed stage, before the next state is attempted.
- If symptoms occur during any stage then stop activity. That stage may be attempted again in 24 hours.
- It is recommended that if a single stage cannot be passed symptom free within 2 attempts then the athlete should return to the Qualified Health Care Provider and report symptoms.
- A player's parent(s) or legal guardian(s) shall be responsible for overseeing the completion of the R.T.P.P.
- Parents/legal guardians may seek assistance for the R.T.P.P., but liability for an accurate and completed protocol will reside with the parents/legal guardians.
- Once the protocol has been completed, and athlete has received the *final signature* from the Qualified Health Care Provider *(page2)*, this information must be emailed, faxed or delivered to the appropriate administration *(Appropriate Administration is defined in the UYSA Concussion Policy).*

RETURN TO PLAY PROTOCOL (R.T.P.P.)

Stage	**Exercises and Activities** *(Examples)*	**Experience any symptoms** *(circle)*	**Date Tested**	**Date Completed** (Adult Initials)
1. Aerobic & Jogging	50%-75% of estimated maximum heart rate for up to 30 minutes. -**NO Heading Allowed**. -**NO contact with another player**. *-Conditioning based to see reactions to the brain with an increased heart rate.*	Yes No		
2. Full Practice NO HEADING	Released to practice with the team, but must avoid excessive contact. -**NO Heading Allowed**. -Free to play, but must avoid head contact with any object. *-Confirm that stress of playing does not cause symptoms to reoccur.*	Yes No		
3. Full Practice No Restrictions	Release to full practice with no restrictions. **-Heading IS Allowed**. -Final test before receiving approval from Qualified Health Care Provider. *-Confirm that playing at full speed and with contact does not cause symptoms to reoccur.*	Yes No		

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Player Symptom Tracking Sheet

- To be filled out on a daily basis until are symptoms scores are "0"
- Preferably done at the same time every day ± 2 hours.

Name:_____ Date: _____ Completed by Self ☐ Other☐ _____

Instructions: For each item indicate how much the symptom has bothered you *today.*

Severity Rating			
None	Mild	Moderate	Severe
0	1 – 2	3 – 4	5 – 6

	Symptoms	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Physical	Headache							
	Nausea							
	Vomiting							
	Balance Problems							
	Dizziness							
	Visual Problems							
	Fatigue							
	Sensitivity to Light							
	Sensitivity to Noise							
	Numbness/Tingling							
Thinking	Feeling Mentally Foggy							
	Feeling Slowed Down							
	Difficulty Concentrating							
	Difficulty Remembering							
Sleep	Drowsiness							
	Sleeping Less than Usual							
	Sleeping More than Usual							
	Trouble Falling Asleep							
Emotional	Irritability							
	Sadness							
	Nervousness							
	Feeling more Emotional							
	Pain other than Headache							

Pain other than Headache: (please specify location): _____

UTAH YOUTH SOCCER ASSOCIATION
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PHYSCIAN EVALUATION FORM

ACUTE CONCUSSION EVALUATION (ACE)
CARE PLAN

Gerard Gioia, PhD[1] & Micky Collins, PhD[2]
[1]Children's National Medical Center
[2]University of Pittsburgh Medical Center

Patient Name:_____
DOB: _____ Age:_____
Date:_____ ID/MR#_____
Date of Injury:_____

You have been diagnosed with a concussion (also known as a mild traumatic brain injury). This personal plan is based on your symptoms and is designed to help speed your recovery. Your careful attention to it can also prevent further injury.

Rest is the key. You should not participate in any high risk activities (e.g., sports, physical education (PE), riding a bike, etc.) if you still have any of the symptoms below. It is important to limit activities that require a lot of thinking or concentration (homework, job-related activities), as this can also make your symptoms worse. If you no longer have any symptoms and believe that your concentration and thinking are back to normal, you can slowly and carefully return to your daily activities. Children and teenagers will need help from their parents, teachers, coaches, or athletic trainers to help monitor their recovery and return to activities.

Today the following symptoms are present (circle or check). ____**No reported symptoms**

Physical		Thinking	Emotional	Sleep
Headaches	Sensitivity to light	Feeling mentally foggy	Irritability	Drowsiness
Nausea	Sensitivity to noise	Problems concentrating	Sadness	Sleeping more than usual
Fatigue	Numbness/Tingling	Problems remembering	Feeling more emotional	Sleeping less than usual
Visual problems	Vomiting	Feeling more slowed down	Nervousness	Trouble falling asleep
Balance Problems	Dizziness			

RED FLAGS: Call your doctor or go to your emergency department if you suddenly experience any of the following			
Headaches that worsen	Look very drowsy, can't be awakened	Can't recognize people or places	Unusual behavior change
Seizures	Repeated vomiting	Increasing confusion	Increasing irritability
Neck pain	Slurred speech	Weakness or numbness in arms or legs	Loss of consciousness

Returning to Daily Activities

1. Get lots of rest. Be sure to get enough sleep at night- no late nights. Keep the same bedtime weekdays and weekends.
2. Take daytime naps or rest breaks when you feel tired or fatigued.
3. **Limit physical activity as well as activities that require a lot of thinking or concentration. These activities can make symptoms worse.**
   - Physical activity includes PE, sports practices, weight-training, running, exercising, heavy lifting, etc.
   - Thinking and concentration activities (e.g., homework, classwork load, job-related activity).
4. Drink lots of fluids and eat carbohydrates or protein to main appropriate blood sugar levels.
5. **As symptoms decrease, you may begin to gradually return to your daily activities. If symptoms worsen or return, lessen your activities, then try again to increase your activities gradually.**
6. During recovery, it is normal to feel frustrated and sad when you do not feel right and you can't be as active as usual.
7. Repeated evaluation of your symptoms is recommended to help guide recovery.

Returning to School

1. If you (or your child) are still having symptoms of concussion you may need extra help to perform school-related activities. As your (or your child's) symptoms decrease during recovery, the extra help or supports can be removed gradually.
2. Inform the teacher(s), school nurse, school psychologist or counselor, and administrator(s) about your (or your child's) injury and symptoms. School personnel should be instructed to watch for:
   - Increased problems paying attention or concentrating
   - Increased problems remembering or learning new information
   - Longer time needed to complete tasks or assignments
   - Greater irritability, less able to cope with stress
   - Symptoms worsen (e.g., headache, tiredness) when doing schoolwork

~Continued on back page~

This form is part of the "Heads Up: Brain Injury in Your Practice" tool kit developed by the Centers for Disease Control and Prevention (CDC).

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PHYSCIAN EVALUATION FORM

Returning to School (Continued)

Until you (or your child) have fully recovered, the following supports are recommended: *(check all that apply)*

__No return to school. Return on (date)_____

__Return to school with following supports. Review on (date)_____

__Shortened day. Recommend ___ hours per day until (date)_____

__Shortened classes (i.e., rest breaks during classes). Maximum class length: _____ minutes.

__Allow extra time to complete coursework/assignments and tests.

__Lessen homework load by _____%. Maximum length of nightly homework: _____ minutes.

__No significant classroom or standardized testing at this time.

__Check for the return of symptoms (use symptom table on front page of this form) when doing activities that require a lot of attention or concentration.

__Take rest breaks during the day as needed.

__Request meeting of 504 or School Management Team to discuss this plan and needed supports.

Returning to Sports

1. **You should NEVER return to play if you still have ANY symptoms** – (Be sure that you do not have any symptoms at rest and while doing any physical activity and/or activities that require a lot of thinking or concentration.)
2. Be sure that the PE teacher, coach, and/or athletic trainer are aware of your injury and symptoms.
3. It is normal to feel frustrated, sad and even angry because you cannot return to sports right away. With any injury, a full recovery will reduce the chances of getting hurt again. It is better to miss one or two games than the whole season.

The following are recommended at the present time:

___ Do not return to PE class at this time

___ Return to PE class

___ Do not return to sports practices/games at this time

___ **Gradual** return to sports practices under the supervision of an appropriate health care provider (e.g., athletic trainer, coach, or physical education teacher).

- Return to play should occur in gradual steps beginning with aerobic exercise only to increase your heart rate (e.g., stationary cycle); moving to increasing your heart rate with movement (e.g., running); then adding controlled contact if appropriate; and finally return to sports competition.
- Pay careful attention to your symptoms and your thinking and concentration skills at each stage of activity. Move to the next level of activity only if you do not experience any symptoms at the each level. If your symptoms return, let your health care provider know, return to the first level, and restart the program gradually.

Gradual Return to Play Plan

1. No physical activity
2. Low levels of physical activity (i.e., *symptoms do not come back during or after the activity*). This includes walking, light jogging, light stationary biking, light weightlifting (lower weight, higher reps, no bench, no squat).
3. Moderate levels of physical activity with body/head movement. This includes moderate jogging, brief running, moderate-intensity stationary biking, moderate-intensity weightlifting (reduced time and/or reduced weight from your typical routine).
4. Heavy non-contact physical activity. This includes sprinting/running, high-intensity stationary biking, regular weightlifting routine, non-contact sport-specific drills (in 3 planes of movement).
5. Full contact in controlled practice.
6. Full contact in game play.

*Neuropsychological testing can provide valuable information to assist physicians with treatment planning, such as return to play decisions.

This referral plan is based on today's evaluation:

___ Return to this office. Date/Time_____

___ Refer to: Neurosurgery____ Neurology____ Sports Medicine____ Physiatrist____ Psychiatrist____ Other____

___ Refer for neuropsychological testing

___ Other_____

ACE Care Plan Completed by:_____ **MD RN NP PhD ATC**

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CONCUSSION DIAGNOSIS FORM

For the **USE** and **RECORD** of the Q.H.C.P. making the initial diagnosis
(Please tear this sheet from the packet and keep for your personal records)

PLAYERS INFORMATION

_____ _____ U-_____ _____
Players Name *Team Name* *Age* *Event (i.e. tournament, season game)*

_____/_____/_____ _____/_____/_____ _____ AM PM _____/_____ /_____
Date of Injury *Date of Initial Exam* *Time of Exam* *Date of Birth*

The athlete will be released to, _____ who is an adult over the age of 18, and is capable of monitoring the above named athletes medical condition. If the above named adult is not the parent/legal guardian of the above named athlete, then they are responsible for monitoring the named athlete's progress until a parent/legal guardian is present, or until athlete is under the care of a medical professional. If the individual's symptoms worsen then immediate medical attention is needed, and required.

_____ (_____)_____-_____ _____/_____/_____
Signature of Person Responsible for Monitoring Progress *Contact Info.* *Date*

SIGNS AND SYMPTOMS

Did the athlete suffer Loss of Conscious: Yes No Unknown

Headache	Slow to Respond	Difficulty Balancing	Slurred Speech	Retrograde Amnesia	Anterograde Amnesia	Nervousness
Dizzy	Dazed	Photophobia	Tinnitus	Fatigue	Depressed	Confused
Nausea	Vomiting	Diplopia	Foggy	Sadness	Nervous	Irritable

Notes:

*** If more space is needed, please use the back of the page.

_____ _____/_____/_____
Health Professional Signature *Date*