Florida Youth Soccer Association

Post Head Injury/Concussion Medical Clearance for Return to Participation

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This form is to be completed by an appropriate health care provider (AHCP-MD/DO) trained in the latest concussion evaluation and management protocols as defined in FL Statute 943.0438 for any youth player that has sustained a concussion and must be kept on file with the FYSA affiliate. The choice of AHCP remains the decision of the parent/guardian or responsible party of the youth player.

Athlete Name: _____ DOB: _____/_____/_____ Injury Date: _____/_____/_____

Affiliate Club & Code: _____ Team &Team Code: _____

Location of Injury: _____

By signing below, I certify that I am a medical doctor (MD/DO) familiar with the most current 2016 Consensus Statement on Concussion in Sport and the tools used for evaluation (ex. SCAT5). This information will be used to guide return to play progression (page 1) and final clearance to return to competition.

Physician Name: _____ Signature/Degree: _____MD/DO

Phone: _____ Fax: _____ Today's Date: _____

Recommended Graded Return to Play Protocol

After a brief period of initial rest (24-48 hr), symptom-limited activity can begin while staying below a cognitive and physical exacerbation threshold.

Once concussion-related symptoms have resolved, the youth player should continue to proceed to the next level if he/she meets all criteria without recurrence of symptoms. Generally each step should take at least 24 hrs, however, this time frame may vary with player age, history, level of sport, etc., and management must be individualized.

If the youth player experiences a return of any of his/ her concussion symptoms while attempting a graded return to play, the youth player is instructed to stop play immediately and notify a parent, licensed athletic trainer or coach.

Rehabilitation stage	Functional exercise at each stage	Objective	Date completed	Initials
1. Symptom limited activity	Daily activities that do not provoke symptoms	Gradual reintroduction of work/school activities	Noted above	Signed above
2. Light aerobic exercise	Walking, swimming, stationary bike, HR<70% maximum; no weight training	Increased heart rate		
3. Sport-specific exercise	Non-contact drills, running drills: no impact	Add movement		
4. Non-contact training	Complex (non-contact) drills/practice	Exercise, coordination and cognitive load		
5. Full contact practice	Full contact practice, normal activities	Restore confidence and simulate game situations		
6. Return to full activity	Return to competition	**After completion of the steps above; Form AT18, Page 2 must be completed by physician**		

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Return to Competition Affidavit

Participant Name: _____

Date of Birth: _____/_____/_____ Injury Date: _____/_____/_____

Formal Diagnosis: _____

Club Affiliate _____

Team: _____

I certify that I have reviewed the graded return to activity protocol provided to me on behalf of the athlete named above.
This youth player is cleared for a complete return to **full-contact physical activity** as of _____/_____/_____.

This youth player is instructed to stop play immediately and notify a parent, licensed athletic trainer or coach and to refrain from activity should his/her symptoms return.

Physician Name: _____

Physician Signature:_____ MD/DO License No.: _____

Phone: (_____) _____ Fax: (_____) _____ E-mail: _____

Date: _____/_____/_____

By signing above, I certify that I am a medical doctor (MD/DO) familiar with the most current 2016 Consensus Statement on Concussion in Sport and the tools used for evaluation (ex: SCAT5). This information will be used to guide return to play progression (page 1) and final clearance to return to competition.