Exhibit – Return-to-Play Consent Form
No Concussion

Student Information

Student's Name:_____
First *Middle* *Last*

Date of Birth:_____ Grade:_____

Student and Parent/Guardian Certification
(Must be signed before graduated return-to-play may begin)

We, the Student and Parent/Guardian of the Student listed above, certify that:

(1) We have been informed concerning and consent to the Student participating in the return-to-learn and return-to-play protocols *(Administrative Procedure 7.305-AP2)*;
(2) We understand the risks associated with the Student returning to learn and returning to play and will comply with any ongoing requirements in the return-to-learn and return-to-play protocols;
(3) We consent to the disclosure to appropriate persons, consistent with the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), of this Return-to-Play Consent Form and, if any, the return-to-play recommendations of the treating physician, physician assistant (PA), advanced practice registered nurse (APRN), or licensed athletic trainer, as the case may be; and
(4) We consent to the Student returning to interscholastic athletic activities in accordance with Administrative Procedure 7.305-AP2 Concussion Care Protocol – Return-to-Learn and Return-to-Play, which states that for any student who has been removed from an interscholastic athletic activity due to symptoms of a concussion and evaluated and determined by a physician, PA, APRN, or licensed athletic trainer not to have sustained a concussion, the student must wait at least 24 hours after such determination AND be observed by an athletic trainer or coach during at least one non-contact practice with NO symptoms before returning to contact sports. If any symptom returns with physical exertion, the student will be deemed to have a possible or probable concussion and will be subject to the full Graduated Six Step Return-to-Play protocol.

Student *Signature*:_____ *Date*:_____

Parent/Guardian *Signature*:_____ *Date*:_____

Medical Professional Certification

By signing below, I certify that:

(1) I am the Student's treating physician, physician assistant, advanced practice registered nurse, or athletic trainer working under the supervision of a physician;
(2) I have evaluated the Student using established medical protocols based on peer-reviewed scientific evidence consistent with Centers for Disease Control and Prevention guidelines; and
(3) In my professional judgment NO concussion has been sustained and it is safe for the Student to return to interscholastic athletic activities in accordance with Administrative Procedure 7.305-AP2 Concussion Care Protocol – Return-to-Learn and Return-to-Play,

which states that for any student evaluated and determined by a physician, PA, APRN, or licensed athletic trainer not to have sustained a concussion, the student must wait at least 24 hours after such determination AND be observed by an athletic trainer during at least one non-contact practice with NO symptoms before returning to contact sports. If any symptom returns with physical exertion, the student will be deemed to have a possible or probable concussion and will be subject to the full Graduated Six Step Return-to-Play protocol.

Physician, PA, APRN, Licensed Athletic Trainer Name (*please print*):

_____

Signature:_____ *Date*:_____

Contact information:_____

Scheduled Date for Follow-Up Appointment:_____