DALLAS INDEPENDENT SCHOOL DISTRICT | Sports Medicine

CONCUSSION RETURN TO PLAY PROTOCOL

Name: _____ School: _____

STEP 1
24-hour period of being asymptomatic

STEP 2
Ride bike for 5 to 10 minutes

☐Yes ☐ No Asymptomatic?

Athletic Trainer: _____ Date: _____

STEP 3
250-yard test: ☐Yes ☐ No Asymptomatic?

50-yard sprint

50-yard back pedal

50-yard side shuffle

50-yard side shuffle

50-yard Z-pattern

Illinois test: ☐Yes ☐ No Asymptomatic?

Perform test twice (switch the start and finish between each test). Times of the two test should be within 2 seconds.

20 up-downs: ☐Yes ☐ No Asymptomatic?

Athletic Trainer: _____ Date: _____

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STEP 4
Full practice without contact or equivalent

☐Yes ☐No Asymptomatic?

Athletic Trainer: _____ Date: _____

STEP 5
Full practice with contact or equivalent

☐Yes ☐No Asymptomatic?

Athletic Trainer: _____ Date: _____

STEP 6
Full return to play

Athletic Trainer: _____ Date: _____

Per physician recommendation, generally speaking a 24-hour period between each step is recommended. If any post-concussion symptoms occur during the Return to Play Protocol progress will stop until symptoms have cleared. Once asymptomatic for 24-hours, the athlete will repeat the previous step.

Concussion Management Protocol Return to Play Form

This form must be completed and submitted to the athletic trainer or other person (who is not a coach) responsible for compliance with the Return to Play protocol established by the school district Concussion Oversight Team, as determined by the superintendent or their designee (see Section 38.157 (c) of the Texas Education Code).

_____ _____

Student Name (Please Print) *School Name (Please Print)*

Designated school district official verifies:

Please Check

☐ The student has been evaluated by a treating physician selected by the student, their parent or other person with legal authority to make medical decisions for the student.

☐ The student has completed the Return to Play protocol established by the school district Concussion Oversight Team.

☐ The school has received a written statement from the treating physician indicating, that in the physician's professional judgment, it is safe for the student to return to play.

_____ _____

School Individual Signature *Date*

_____

School Individual Name (Please Print)

Parent, or other person with legal authority to make medical decisions for the student signs and certifies that he/she:

Please Check

☐ Has been informed concerning and consents to the student participating in returning to play in accordance with the return to play protocol established by the Concussion Oversight Team.

☐ Understands the risks associated with the student returning to play and will comply with any ongoing requirements in the return to play protocol.

☐ Consents to the disclosure to appropriate persons, consistent with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), of the treating physician's written statement under Subdivision (3) and, if any, the return to play recommendations of the treating physician.

☐ Understands the immunity provisions under Section 38.159 of the Texas Education Code.

_____ _____

Parent/Responsible Decision-Maker Signature *Date*

_____

Parent/Responsible Decision-Maker Name (Please Print)