



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 I (Limited Physical Activity);
- Step II-A (Light aerobic activity);
- Step II-B (Moderate aerobic and/or light resistance training);
- Step II-C (Strenuous aerobic activity and/or moderate resistance training)
- Step II-D (Non-contact training; full weightlifting; Sport-specific drills; *Need MD note and no symptoms to progress to Step III*)
- Step III (Limited contact sports; in practice only; *Need one contact practice before Step IV*)
- Step IV (Return to play; including 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:

- Yes No or Unsure [Comment: _____]

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.