AKRON CENTRAL SCHOOL

"HEADS UP" Concussion Progressive Return to Play Program

STUDENT'S NAME_____D.O.B._____ GRADE_____

The above named student and/or athlete has been diagnosed, medically managed and has been cleared by their private physician to return to physical education and/or sports. The Health Office has the 'return to gym/sports' note from the student's physician on file in the Health Office. **A qualified person, designated by the Athletic Director, will conduct the Return to Play Program.**

PROGRESSIVE RETURN TO PLAY PROGRAM

GOAL: To progress the student and/or athlete back into physical education and/or sports in a safe and productive manor. The Progressive Return to Play Program will be conducted over a period of several days. The student and/or athlete will return to physical activity only after successful completion of the program and he/she remains symptom-free of a concussion. Any return of symptoms during the Return to Play Program, the student will return to the previous day's activities until they are symptom free.

DATE:_____/_____/_____	**Day 1 –** Begin with 10 minutes of low impact, non-strenuous, light aerobic activity. No weight lifting, jumping or running.
DATE:_____/_____/_____	**Day 2 –** Increase the athlete's heart rate, but incorporate limited body and/or head movements. This includes higher impact, higher exertion and moderate aerobic activity.
DATE:_____/_____/_____	**Day 3 –** Bump it up a notch. This includes sport specific, non-contact activity. Low resistance weight training with a spotter.
DATE:_____/_____/_____	**Day 4 –** Reintegrate the athlete in practice sessions. Sport specific activity, non-contact drills. Higher resistance weight training with a spotter.
DATE:_____/_____/_____	**Day 5 –** Full contact training drills with intensive aerobic activity.
DATE:_____/_____/_____	**Day 6 –** Signs and/or symptoms of concussion resolved and has been symptom-free for 24 hours. May resume full physical education and/or sports activities with **clearance from the Athletic Director.**

Report completed by:_____ Title:_____ Date:____/_____/_____

The above named student has successfully completed the Progressive Return to Play Program and may return to physical education and/or sports activities.

Athletic Director Signature_____ Date:_____/_____/_____

RETURN TO HEALTH OFFICE UPON COMPLETION

Developed by J. Fix, R.N. – approved by S. Dimitroff (Revised 1/30/13)