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 “Return to Play” form):  check one

☐ Step 1 (Limited Physical Activity);
☐ Step 2 (Light aerobic activity);
☐ Step 3 (Moderate aerobic and/or light resistance training);
☐ Step 4 (Heavy, non-contact activity and/or moderate resistance training)
☐ Step 5 (Practice and full contact)
☐ Step 6 (Returned to 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.