UA SPORT CLUB RETURN TO PLAY CLEARANCE FORM

For questions concerning this form please contact the Competitive Sports Coordinator or Assistant Director at (205)348-8055.

_____(name) suffered a suspected head injury on _____(date). As a University of Alabama Sport Club participant in _____(sport), the following form must be submitted by the participant to the Sport Club Office in order to return to play.

Notes to Participant: You must complete a SCAT5 Test within 24-72 hours after your injury by contacting Drayer Sports Medicine at (205) 348-3904. After the post-injury test, a *qualified physician must clear you in writing before returning to play. You should be symptom free for at least 24 hours prior to seeking medical clearance. The CDC recommends a return to play progression.

Return immediately to the emergency department if you experience any of the following symptoms:
(From CDC What to expect after a concussion)

- Repeated vomiting
- Headache that gets worse and does not go away
- Loss of consciousness or unable to stay awake during times you would normally be awake
- Getting more confused, restless, or agitated
- Convulsions or seizures
- Difficulty walking or difficulty with balance
- Weakness or numbness
- Difficulty with your vision

Important things to tell your physician:

- Cause of the injury and force of the hit or blow to the head or body
- Any loss of consciousness (passed out / knocked out) and if so, for how long
- Any memory loss or seizures immediately following the injury
- Number of previous concussions (if any)
- Duration of symptoms

Concussion symptoms differ with each person and with each injury, and they may not be noticeable for hours or days. Common symptoms include:

- Headache
- Confusion
- Difficulty remembering or paying attention
- Balance problems or dizziness
- Feeling sluggish, hazy, foggy, or groggy
- Feeling irritable, more emotional, or “down”
- Nausea or vomiting
- Bothered by light or noise
- Double or blurry vision
- Slowed reaction time
- Sleep problems
- Loss of consciousness

I hereby authorized the above named participant for return to play in athletic activities.

Physician Signature:_____ Date:_____

Physician Name: _____ Phone:_____

Name of Practice:_____

Qualified Physician: a physician, trained in the diagnosis, evaluation, and management of concussions. CDC Clinician’s Resource available at http://www.cdc.gov/concussion/HeadsUp/clinicians/index.html and http://www.cdc.gov/concussion/HeadsUp/physicians_tool_kit.html.

Competitive Sports Office Use Only:

Received by:_____ Date:_____

Participant and Club President Notified:_____ Drayer Notified & Copied:_____