Appendix C-4

Documentation for a Diagnosed Concussion – Return to Learn/Return to Physical Activity Plan

The Return to Learn/Return to Physical Activity Plan is a combined approach. Parts A and B (Return to Learn) must be completed prior to the Student returning to physical activity. Each Part must take a minimum of 24 hours.

Part A – Physical and Cognitive Home Rest

- *Completed at home.*
- *Cognitive Rest – includes limiting activities that require concentration and attention (e.g., reading, texting, television, computer, video/electronic games).*
- *Physical Rest – includes restricting recreational/leisure and competitive physical activities.*

☐ My child/ward has completed Part A – Physical and Cognitive Home Rest and his/her **symptoms have shown improvement**. My child/ward will proceed to Part B – Return to Learn.

☐ My child/ward has completed Part A - Physical and Cognitive Home Rest and is **symptom free**. My child/ward will proceed directly to Part C -Return to Physical Activity.

Parent/Guardian signature: ________________________________ Date: _____________________

Comments:

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If at any time during the following steps symptoms return, please refer to the "Return of Symptoms" section on page 4 of this form.

Part B – Return to Learn

- *Student returns to school.*
- *Requires individualized classroom strategies and/or approaches which gradually increase cognitive activity.*
- *Physical rest- includes restricting recreational/leisure and competitive physical activities.*

☐ My child/ward has been receiving individualized classroom strategies and/or approaches and is **symptom free**. My child/ward will return to regular learning activities at school. My child/ward will proceed to Part C – Return to Physical Activity.

Parent/Guardian signature: ______________________________ Date: ____________________

Comments:

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Part C – Return to Physical Activity

(i.) Light Aerobic Physical Activity

- Student can participate in individual light aerobic physical activity only.
- Student continues with regular learning activities.

☐ My child/ward is symptom free after participating in light aerobic physical activity. My child/ward will proceed to Part C (ii) – Sport Specific Physical Activity.

Parent/Guardian signature: ______________________________ Date: ____________________

Comments:

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(ii.) Sport Specific Physical Activity (non-contact)

- *Student may begin individual sport-specific physical activities only. No body contact and or resistance/weight training.*

(iii.) Return to Non-Sport Specific Physical Activity (non-contact)

- *Student may begin activities where there is no body contact (e.g., dance, badminton); light resistance/weight training; non-contact practice; and non-contact sport-specific drills.*

☐ Student has successfully completed Part C (i, ii, iii) and is symptom free.

Teacher/coach signature: ____

Medical Examination

☐ I, ______________________________ (medical doctor/nurse practitioner name) have examined ______________________________ (child/ward) and confirm he/she continues to be symptom free and is able to return to regular physical education class/intramural activities/interschool activities in non-contact sports and full training/practices for contact sports.

Medical Doctor/Nurse Practitioner Signature: ___________________________________

Date: ____________________

Comments:

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***(iv.)* Return to Regular Non-Contact Physical Activity**

- *Student may resume regular physical education/intramural activities/interschool activities in non-contact sports and full training/practices for contact sports (no contact permitted).*

Return to Physical Activity With No Restrictions

- *Student may resume full participation in contact sports with no restrictions.*

☐ My child/ward is symptom free after participating in *regular non-contact physical activities in non-contact sports and full training/practices for contact sports and is now permitted to return to physical activity with no restrictions.*

Parent/Guardian signature: ________________________________ Date: _____________________

Comments:

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Return of Symptoms

☐ My child/ward has experienced a return of concussion signs and/or symptoms and has been examined by a medical doctor/nurse practitioner, who has advised a return to:

- Step __________ of the Return to Learn/Return to Physical Activity Plan

Parent/Guardian signature: ________________________________ Date: _____________________

Comments:

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