HOUSTON Methodist LEADING MEDICINE

Return to Play Documentation

To be completed within 30 minutes after exercise.

Please place a check in the appropriate box any of the following symptoms
you experienced during school or with the exercise you completed that day.

ATHLETE'S NAME: _____ SPORT: _____

	Stage		Stage		Stage		Stage		Stage		Stage		Stage	
	Date		Date		Date		Date		Date		Date		Date	
Symptom	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Fatigue														
Trouble concentrating														
Trouble remembering														
Drowsiness														
Feeling "in a fog"														
Brain feels slowed down														
Balance problems														
Blurry vision														
Dizziness														
Headache														
Nausea/vomiting														
Neck pain														
Mental Fogginess														
Sensitive to light														
Sensitive to noise														
More irritable														
Visual Problem														
Student Initials:														

This athlete has completed the school district's return to play protocol for his/her sport. To the best of my knowledge, the student is symptom free at rest and did not experience any return of symptoms while progressing through the various phases of activity.

_____
Date

_____
Name - Athletic Trainer or Coach (Print)

_____
Signature of Athletic Trainer or Coach

_____
Print School District and School Name

_____
Signature of Athlete