CHESTERFIELD COUNTY PUBLIC SCHOOLS

CONCUSSION MEDICAL STATUS FORM

Dear Licensed Health Care Provider:

_____, a student at _____ School, was recently removed from a Chesterfield County Public Schools' curricular or extracurricular physical activity due to a suspected concussion on or about _____(Date). Pursuant to School Board Policy 4135 (a copy of which may be found on the school division's website, *mychesterfieldschools.com*, under *School Board/BoardDocs*), the student is prohibited from returning to play in any curricular or extracurricular physical activity unless he or she is first released to return-to-learn by his or her licensed health care provider. Please complete the certifications that follow and sign and print below.

I certify that:

I am a physician, physician assistant, osteopath or athletic trainer licensed by the Virginia Board of Medicine; a neuropsychologist licensed by the Board of Psychology; or a nurse practitioner licensed by the Virginia State Board of Nursing and I am aware of the current medical guidance on concussion evaluation and management, **AND (check all that apply)**:

- ❑ The student **DID NOT** sustain a concussion

OR, ...

- ❑ The student **DID** sustain a concussion, and……
  - ❑ **IS *NEITHER* RELEASED TO RETURN-TO-LEARN or RETURN-TO-PLAY**
  - ❑ **IS RELEASED TO RETURN-TO-LEARN ONLY ("FULL-TIME With Adjustments")**, and to another healthcare provider to begin concussion protocols.
  - ❑ **COMPLETED RETURN-TO-LEARN and is now allowed to begin graduated return to play protocol** per Section V. in Policy 4135. Student is released to another healthcare provider, i.e. certified Athletic trainer, physical therapist, etc. to complete the return-to-play protocol per Section VI.C.i.1. in Policy and begin concussion protocols.
  - ❑ **The student did sustain a concussion and has fulfilled all criteria for RETURN-TO-PLAY by successfully completing the RETURN-TO-PLAY protocol of progressive exercise challenge of a minimum of 5 days.**

_____

Name of Licensed Health Care Provider (Print) *(Signature)*

_____ _____

Office Phone Number *Date*

Parent/Student - Return completed form to:

- **For High School – VHSL Activities - Athletic Trainer/School Nurse**
- **For High School – Non-VHSL Activities - School Nurse/Clinic Assistant**
- **For all Middle School Activities - School Nurse/Clinic Assistant**
- **For all Elementary School Activities - School Nurse/Clinic Assistant**

COPY TO BE RETAINED IN STUDENT's CUMULATIVE SCHOOL FILE

July 2013
REVISED: October 2016, July 2017, April 2018