

RETURN TO ACTIVITY & POST-CONCUSSION CONSENT FORM

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This form is to be used after an athlete is removed from and not returned to activity after exhibiting concussion symptoms. MHSAA rules require 1) Unconditional written authorization from a physician (MD/DO/Physician's Assistant/Nurse Practitioner), and 2) Consent from the student and parent/guardian. **Both Sections 1 & 2 of this form must be completed prior to a return to activity. This form must be kept on file at the school and emailed to Concussion@MHSAA.com or faxed to 517-332-4071.**

Student: _____ School: _____
Event/Sport: _____ Date of Injury: _____

1. Action of M.D., D.O., Physician's Assistant or Nurse Practitioner

- The clearance must be in writing and must be unconditional. It is not sufficient that the M.D., D.O., Physician's Assistant or Nurse Practitioner has approved the student to begin a return-to-activity progression. The medical examiner must approve the student's return to unrestricted activity.
- Individual schools, districts and leagues may have more stringent requirements and protocols including but not limited to mandatory periods of inactivity, screening and post-concussion testing prior to or after the written clearance for return to activity.
- A school or health care facility may use a locally created form for this portion of the return-to-activity protocol, provided it complies with MHSAA regulations. (See MHSAA Protocol.)

I have examined the above named student-athlete following this episode and determined the following: _____

Permission is granted for the athlete to return to activity (may not return to practice or competition on the same day as the injury).

DATE: _____

SIGNATURE (must be MD or DO or PA or NP – circle one)

Examiner's Name (Printed): _____

2. Post-Concussion Consent from Student and Parent/Guardian.

- I am fully informed concerning, and knowingly and voluntarily consent to, my/my child's immediate return to participation in athletic activities; I understand, appreciate, acknowledge, and assume the risks associated with such return to activity, including but not limited to concussions, and agree to comply with all relevant protocols established by my/my child's school and/or the MHSAA; and I/my child has been evaluated by, and has received written clearance to return to activity from an M.D., D.O., Physician's Assistant or Nurse Practitioner.
- In consideration of my/my child's continued participation in MHSAA-sponsored athletics, I/we do hereby waive any and all claims, suits, losses, actions, or causes of action against the MHSAA, its members, officers, representatives, committee members, employees, agents, attorneys, insurers, volunteers, and affiliates based on any injury to me, my child, or any person, whether because of inherent risk, accident, negligence, or otherwise, during or arising in any way from my/my child's participation in an MHSAA-sponsored sport.
- I/we consent to the disclosure to appropriate persons, consistent with HIPAA and FERPA of the treating physician's or athletic trainer's written statement.

Student's Signature (Required): _____ Date: _____

*Parent/Guardian's Name _____ *Parent/Guardian's Signature: _____

**Required if student is less than 18 years of age.*

SEE REVERSE FOR OTHER CONCUSSION RELATED INFORMATION INCLUDING INSURANCE
THIS FORM SHOULD BE KEPT ON FILE AT THE SCHOOL FOR SEVEN YEARS FOLLOWING THE STUDENT'S HIGH SCHOOL GRADUATION.

Print Year of HS Graduation: