Chesterfield County Public Schools
Concussion Medical Status Form

Dear Licensed Healthcare 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 which may be found on the school division 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 healthcare provider. Please complete the certifications that follow and sign and print below.

I certify that:

I am a physician (i.e. MD, D.O.), physician assistant, or athletic trainer licensed by the Virginia Board of Medicine; a neuropsychologist licensed by the Board of Psychology; a physical therapist licensed by the Virginia Board of Physical Therapy 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)**:

RETURN TO LEARN

___ Is **NOT** cleared to return to school.

___Is cleared to return to school *with* accommodations (Please provide specific accommodations in writing).

___Is fully cleared to return to school *with no* accommodations.

RETURN TO PLAY (RTP)

___ Is **NOT** cleared to begin graduated RTP.

___ Is cleared to begin a RTP protocol that is progressive in nature and is monitored by an approved licensed health care professional as defined by CCPS Policy 4135. (Please provide specific protocol in writing including what stage the athlete is cleared up to completing at this time).

___ The student has fulfilled all criteria for RTP by successfully completing a graduated RTP protocol of progressive exercise challenge of a minimum of 5 days.

_____ _____

Name of Licensed Healthcare Provider (Print) *(Signature)*

_____ _____

Office Phone Number *Date*

Parent/Student- Return completed form to: School Nurse/Clinic Assistant/Athletic Trainer

COPY TO BE RETAINED IN STUDENT'S CUMULATIVE SCHOOL FILE