HEADSMART™ SPORTS CONCUSSION PROGRAMME

CONCUSSION CLEARANCE CERTIFICATE

Doctor's Name: ______________________________________

Doctor's Email: ____

Today's date: ___________

Please be advised that:

Athlete / Player Name: ______________________________________ **Concussion date:** ___________

A doctor verifies that all required medical criteria listed below have been met (tick all appropriate):

- ☐ Normal neurological examination
- ☐ Resolved symptoms & signs following rest
- ☐ Comparable after injury test (Cogstate)
- ☐ Completed full school / work day report
- ☐ Completed stage 2-4 exercise programme

Parent / guardian confirms that all required concussion clearance criteria have been met (tick all appropriate):

- ☐ Normal neurological examination
- ☐ Resolved symptoms & signs following rest
- ☐ Comparable after injury test (Cogstate)
- ☐ Completed full school / work day report
- ☐ Completed stage 2-4 exercise programme

Contact training (Stage 5 GRTP) can begin on: ______________

Parent/guardian signature ____ **Todays date:** ______________

School / club programme co-ordinator: ____

Co-ordinator's email address: ____

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