HEADSMART™ SPORTS CONCUSSION PROGRAMME

EXERCISE REHABILITATION PROGRAMME

Athlete / Player Name: _____ **Gender:** Male

DOB: _____ **Age:** ____ **Name of School / Club:** _____

Today's date: _____ **Most recent head injury:** _____

CONTACT DETAILS

Address: _____ **State:** _____ **Postcode:** _____

Mobile: _____ **Email:** _____

Sport/s played: _____

Stage 1

- ☐ Do not resume physical activity until directed by a medical doctor
- ☐ Symptoms subsiding
- ☐ Start balance re-training
- ☐ Doctor's clearance to start exercise

Stage 1 complete

- ☐ Yes
- ☐ No

Stage 2 (low intensity training)

- ☐ Walking, swimming, stationary cycling options only
- ☐ Progress balance training
- ☐ No new symptoms after 24 hours

Duration 20-25 min. Heart rate <100 beats

Stage 2 complete

- ☐ Yes
- ☐ No

Stage 3 (moderate intensity training)

- ☐ Individual, sport-specific drills with change of direction
- ☐ Progress balance training
- ☐ No new symptoms after 24 hours

Duration >30 min. Heart rate >160 beats

Stage 3 complete

- ☐ Yes
- ☐ No

Stage 4

Doctor's certificate required

Certificate attached

- ☐ Yes
- ☐ No

Stage 5

- ☐ Medical clearance certificate for contact training
- ☐ Contact session / practice
- ☐ No new symptoms after 24 hours
- ☐ Doctor clears for game play

Duration >30 min. Heart rate >160 beats

Do have have any of the following (tick all appropriate)?

- ☐ Headache
- ☐ Dizziness
- ☐ Blurred vision
- ☐ Balance problems
- ☐ Don't feel right
- ☐ Fatigue / low energy
- ☐ Nausea / vomiting
- ☐ Other (please specify)

Check for symptoms with each step

List other symptoms: _____

Coach/teacher name: _____ **Coach/teacher email:** _____

Parent/guardian name: _____ **Parent/guardian email:** _____

Doctor's name: _____ **Doctor's email:** _____