St. Clair Catholic District School Board

Clear Form

Documentation for a Diagnosed Concussion: Return to Learn / Return to Physical Activity Plan

The Return to Learn/Return to Physical Activity Plan is a combined approach. Step 2a - Return to Learn must be completed prior to the student returning to physical activity. Each step must take a minimum of 24 hours (Note: Step 2b – Return to Learn and Step 2 – Return to Physical Activity occur concurrently).

Step 1 – Return to Learn/Return to Physical Activity

- *Completed at home.*
- *Cognitive Rest – includes limiting activities that require concentration and attention (e.g., reading, texting, television, computer, video/electronic games).*
- *Physical Rest – includes restricting recreational/leisure and competitive physical activities.*

☐ My child has completed Step 1 of the Return to Learn/Return to Physical Activity Plan (cognitive and physical rest at home) and his/her **symptoms have shown improvement**. My child/ward will proceed to Step 2a – Return to Learn.

☐ My child has completed Step 1 of the Return to Learn/Return to Physical Activity Plan (cognitive and physical rest at home) and is symptom free. My child will proceed directly to Step 2b – Return to Learn and Step 2 – Return to Physical Activity.

Parent/Guardian signature: _____ Date: _____

Comments:

If at any time during the following steps symptoms return, please refer to the "Return of Symptoms" section on page 2 of this form.

Step 2a – Return to Learn

- Student makes gradual return to instructional day.
- Requires individualized classroom strategies and/or approaches which gradually increase cognitive activity.
- Physical rest– includes restricting recreational/leisure and competitive physical activities.

If symptoms persist or worsen return to Step 1 and consult a physician (see page 3 of this form)

☐ My child has made a gradual return to his/her instructional day and has been receiving individualized classroom strategies and/or approaches and is symptom free. My child will proceed to Step 2b – Return to Learn and Step 2 – Return to Physical Activity.

Parent/Guardian signature: _____ Date: _____

Comments:

St. Clair Catholic District School Board

Step 2b – Return to Learn

- Student returns to regular learning activities at school.

Step 2 – Return to Physical Activity

- Student can participate in individual light aerobic physical activity only.
- Student continues with regular learning activities

☐ My child is symptom free after participating in light aerobic physical activity. My child will proceed to Step 3 – Return to Physical Activity.

☐ **Appendix 2 will be returned to the teacher to record progress through steps 3 and 4**

Parent/Guardian signature: _____ Date: _____

Comments:

Step 3 – Return to Physical Activity

- Student may begin individual sport-specific physical activity only.

Step 4a – Return to Physical Activity

- *Student may begin activities where there is no body contact (e.g., dance, badminton); light resistance/weight training; non-contact practice; and non-contact sport-specific drills.*

☐ **Student has successfully completed Steps 3 and 4 and is symptom free.**

☐ **Appendix 2 will be returned to parent/guardian to obtain medical doctor/nurse practitioner diagnosis and signature.**

Teacher signature: _____ Date: _____

Step 4b - Medical Examination:

I, _____(medical doctor/nurse practitioner name) have examined (_____) and confirm he/she continues to be symptom free and is able to return to regular physical education class/intramural activities/interschool activities in non-contact sports and full training/practices for contact sports.

Medical Doctor/Nurse Practitioner Signature: _____ Date: _____

Comments:

Step 5 – Return to Physical Activity

- Student may resume regular physical education/intramural activities/interschool activities in non-contact sports and full training/practices for contact sports.

St. Clair Catholic District School Board

Step 6 – Return to Physical Activity

- Student may resume full participation in contact sports with no restrictions.

Parent/Guardian

☐ My child/ward is symptom free after participating in activities in practice where there is body contact and has permission to participate fully including games.

Parent/Guardian signature: _____ Date: _____

Comments:

Return of Symptoms

☐ My child has experienced a return of concussion signs and/or symptoms and has been examined by a medical doctor/nurse practitioner, who has advised a return to:

Step _____ of the Return to Learn/Return to Physical Activity Plan

Parent/Guardian signature: _____ Date: _____

Comments:

NOTE: Principal / Staff Lead must file this original in the student's OSR.

Principal / Staff Lead signature: _____ Date: _____