



RNC PHYSICIAN CONCUSSION EVALUATION & CLEARANCE FORM

Athlete Information

Today's Date: _____ Date of Injury: _____

Athletes Name: _____ Date of Birth: _____

Club & Team: _____

Concussion History

Date of last concussion: _____ Number of Concussions sustained: _____

How long did it take to recover from most recent concussion: _____

Does the athlete have an ImPACT or SCAT3 Baseline: **Y/N**

Given by: _____ Title: _____

ImPACT/SCAT3 Re-Evaluation completed by: _____ Date: _____

Signature: _____ Title/Role _____

To Be Completed by Physician:

At this time is the athlete is:

Experiencing any concussion signs/symptoms at rest: **Y/N**

If Yes, describe signs/symptoms: _____

Experiencing any concussion signs/symptoms with physical or mental exertion: **Y/N**

If Yes, describe signs/symptoms: _____

Is the athletes ImPACT / SCAT3 score within baseline ranges: **Yes No N/A**

Please initial all of the following that apply

_____ Athlete has a concussion and may not return to physical activity or rugby practices/matches until medically cleared (Rugby NorCal requires full 2 week rest period for any concussion, then 4 stage Graduated Return to Play Protocol)

_____ Athlete is fully symptom free and has completed two week mandatory rest period and may begin Graduated Return To Play (see next page) on (date: _____)

_____ Athlete has been evaluated and assessed as NOT having sustained a concussion and may return to play immediately

Physician Name: _____

Physician Signature: _____

Date: _____ Phone #: _____

Document must be signed by a Physician licensed in the State of California.