

**ANCHORAGE SCHOOL DISTRICT
MEDICAL RELEASE FOR CONCUSSION PATIENT**

Patient Name: _____

Neurocognitive Evaluation Date: _____

Date of Birth: _____

Important Note to Provider: Per AS 14.30.142, a student who has been removed from participation in a practice or game for suspicion of concussion may not return to play until the student has been evaluated and cleared for participation by a qualified person *who has received training and is currently certified in the evaluation and management of concussions*. “Qualified person” means either: 1) a health care provider licensed in Alaska, or exempt from licensure under Alaska law; or 2) a person acting at the direction and under the supervision of a physician licensed in Alaska, or exempt from licensure under AS 08.64.370(1), (2), or (4). **If you do not meet these criteria, please refer Patient to a qualifying provider.**

Neurocognitive Evaluation Required: The Anchorage School District requires that a medical release to return to sports participation following a concussion be based upon a neurocognitive assessment or evaluation. A physical examination, alone, is not sufficient.

COMPLETE RETURN TO ACTIVITY, UNRESTRICTED:

The patient named above is cleared for a complete return to full sports participation as of _____ [date]. The patient is instructed to stop play immediately and notify the coach or nurse should his/her symptoms return.

RETURN TO GRADUATED ACTIVITY:

The patient named above is cleared for graduated return to sports participation as of _____ [date]. Graduated return to full activity is to be accomplished as follows: (Please address, as applicable, the level of activity permitted, and applicable date, for participation in sports, P.E., classroom work and homework.)

The patient is instructed to stop play immediately and notify the coach or nurse should his/her symptoms return during the graduated return to play. Should symptoms present, the student is no longer cleared for participation in graduated return to play.

Provider Signature _____ Date _____

Provider Certification (AS 14.30.142): By signing this form, I affirm that I am a qualified person within the meaning of AS 14.30.142 and that I have received training and am currently certified in the evaluation and management of concussions.

PLACE MEDICAL PROVIDER INFORMATION STAMP HERE,
INCLUDING ADDRESS AND PHONE NUMBER
