Hockey Canada Concussion Policy – Return to Play Requirements

PLAYERS NAME: _____ DATE: _____
(DAY / MONTH / YEAR)

1. Observable Signs

_____
_____

2. Symptoms

_____
_____

3. Memory Assessment

_____
_____

6 STEPS REQUIRED TO RETURN TO PLAY

1. After a period of physical and mental rest, light activities no longer aggravates symptoms or make symptoms worse

DATE: _____
(DAY / MONTH / YEAR)

2. After completing step 1, light aerobic exercise no longer aggravates symptoms or make symptoms worse

DATE: _____
(DAY / MONTH / YEAR)

3. After completing step 2, sport specific activities, such as skating, no longer aggravates symptoms or make symptoms worse

DATE: _____
(DAY / MONTH / YEAR)

4. After completing step 3 and after medical clearance has been authorized, drills without body contact and light resistance training no longer aggravates or make symptoms worse

DATE: _____
(DAY / MONTH / YEAR)

5. After completing step 4 and after medical clearance has been authorized, drills with body contact no longer aggravates or make symptoms worse

DATE: _____
(DAY / MONTH / YEAR)

6. After completing step 5 and after medical clearance has been authorized, a full game no longer aggravates or make symptoms worse

DATE: _____
(DAY / MONTH / YEAR)

Return to Play – Doctor's Authorization

Please forward to:
Okotoks Minor Hockey Association
Box 1152
Okotoks, Alberta T1S 1B2

DATE: _____
(DAY / MONTH / YEAR)

PATIENTS NAME: _____ MALE/FEMALE (CIRCLE)

D.O.B. _____
(DAY / MONTH / YEAR)

I DECLARE THAT THIS PATIENT IS HEREBY MEDICALLY CLEARED TO RETURN TO HOCKEY WITH

____ NO RESTRICTIONS

____ RESTRICTIONS

FOLLOWING _____(INJURY) INJURIES SUSTAINED on _____, 20 ____.

DESCRIPTION OF RESTRICTIONS (AS REQUIRED)

_____
_____

PHYSICIANS NAME (PRINT) _____
PHYSICIANS SIGNATURE _____
LEGAL GUARDIAN NAME (PRINT) _____
LEGAL GUARDIAN SIGNATURE _____

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