Dear Physician,

Your patient ______________________________ sustained a head injury on _________________ during an athletic activity with the Medford Public Schools. In accordance with Massachusetts General Law 105 CMR 201.000, we have developed a policy that every student with a suspected or diagnosed concussion must be evaluated and cleared by their physician or primary care provider before they return to their regular academic and sports activities.

To facilitate the students’ return to activities, please complete the attached re-entry form, stipulating the date that the student may return to usual school activities, and what restrictions, if any, should be placed upon their academic activities. If there are restrictions placed on their academic activities, please provide a date by which the student will be re-evaluated. This form, including possible modifications, was based upon the Boston Children’s Hospital, Sports Medicine Division protocol.

Once students are asymptomatic with their academic work, they will be allowed to gradually return to their athletic activities in accordance with the following protocol. **Each exercise stage begins once athlete is completely asymptomatic at rest. All stages must be completed one day at a time and the athlete must remain asymptomatic during each stage.**

<table>
<thead>
<tr>
<th>Rehabilitation Stage</th>
<th>Functional Exercise at Each Stage of Rehabilitation</th>
<th>Objective of Each Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No activity</td>
<td>Complete physical and cognitive rest</td>
<td>Recovery</td>
</tr>
<tr>
<td>Light aerobic exercise</td>
<td>Walking, stationary bike or elliptical keeping intensity &lt; 70% of Max HR; no resistance training</td>
<td>Increase Heart Rate</td>
</tr>
<tr>
<td>Sport-specific exercise</td>
<td>Sport-specific drills: ie. Running and cutting drills for football and soccer, skating drills for ice hockey, stick work for lacrosse: no head impact activities</td>
<td>Add movement</td>
</tr>
<tr>
<td>Non-contact practice</td>
<td>Progression to more complex training drills: ie. passing drills for football, soccer, and ice hockey; May start progressive resistance training</td>
<td>Exercise, coordination and cognitive load</td>
</tr>
<tr>
<td>Full contact practice</td>
<td>Following medical clearance; participate in normal training activities such as tackling in football, heading in soccer, contact in ice hockey and lacrosse</td>
<td>Restore athlete’s confidence and assess functional skills by coaching staff</td>
</tr>
<tr>
<td>Return to play</td>
<td>Normal game play</td>
<td></td>
</tr>
</tbody>
</table>

***adapted from the Consensus Statement on Concussion in Sport; Zurich, Switzerland, November 2008***
Your signature on this letter indicates that you have examined the student and agree that once he/she is asymptomatic during normal school work, they may follow the athletic re-entry protocol under direct supervision of the licensed district athletic trainer. The athletic trainer will use a standardized instrument to assess the students for symptoms at each progressive stage of activity.

Emergence of symptoms will result in a return to the previous rehabilitation stage of activity after a 24 hour period of asymptomatic rest.

If you have questions about this protocol or policy, please contact Dr. Patrick Sabia, School Physician for the City of Medford at 781-306-0200.

I have evaluated ___________________________ and agree with the student’s return to academic activities, on _________ date, in accordance with the Medford Public School’s protocol described on page 1.

I have evaluated ___________________________ and would like to put the following restrictions into effect instead of following the Medford Public School’s protocol:

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

____________________________
Physician Name

____________________________
Physician signature

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