



**Post-Concussion: Return to Play Progress Questionnaire**

*To be completed by non-medical personnel (e.g., coaches, PE teachers, health technicians, special-ed health technicians) to document a student’s daily progress towards “Return to Play”*

Student’s Name: \_\_\_\_\_ Date: \_\_\_\_\_

School staff member completing form: \_\_\_\_\_ (name);  
\_\_\_\_\_ (job title)

**Today this student participated in the following level of activity (as defined on district “Return to Play” form):** *check one*

- Step 0 (No physical activity other than walking);
- Step 1 (Light aerobic activity);
- Step 2 (Moderate aerobic and/or light resistance training);
- Step 3 (Heavy, non-contact activity and/or moderate resistance training)
- Step 4 (Practice and full contact)
- Step 5 (Returned to competition)

**After this activity, I inquired, and the student reported the following (check all that apply):**

- Confusion or foggy feeling    Nausea or vomiting    Dizziness or seeing stars    Ringing in ears
- Developed a headache    Slurred speech    Delayed response to questions    Light sensitive
- Noise sensitive    More fatigue than expected    Irritability or personality change
- No symptoms at all

**In responding to this, the student appeared to be truthful to me:**

- Yes    No or  Unsure [Comment: \_\_\_\_\_]

\_\_\_\_\_  
Signature of staff member

\_\_\_\_\_  
Date

*Completed forms are to be shared with school nurse (and athletic trainer, if an athlete).  
File form in the school site health office;*

*The school nurse may share this information with physician who is co-managing the student’s post-concussion, “Return to Play” plan.*