HOUSTON Methodist ORTHOPEDICS & SPORTS MEDICINE

Challenge Soccer Club Return to Play Documentation

Athletes Name: _____

Please place a check in the appropriate box if you experienced any of the following symptoms during school or with the exercise you completed today.

Day 1 – Light aerobic exercise 15 minutes
Day 2 – Moderate intensity aerobic exercise – 30 minutes
Day 3 – Non-Contact training drills, full practice (**NO CONTACT)**
Day 4 – Full contact practice training with heading

Symptom	Day 1		Day 2		Day 3		Day 4	
	Date		Date		Date		Date	
	Yes	No	Yes	No	Yes	No	Yes	No
Trouble Concentrating								
Trouble Remembering								
Drowsiness								
Feeling "in a fog"								
Feeling like your brained is slowed down								
Balance Problems								
Blurry Vision								
Headache								
Nausea/Vomiting								
Neck Pain								
Numbness or tingling								
Sensitive to light								
Sensitive to noise								
More Irritable								

This athlete has completed the return to play protocol for Challenge Soccer Club. To the best of my knowledge, the student is symptom free at rest and did not experience any return of symptoms while progressing through the various stage of activity.

_____ _____
Athletic Trainer/Coach Date

☐ This athlete is cleared for participation

☐ This athlete requires a visit prior to clearance

_____ _____
Treating Physician Date