



## Graduated Return to Play (G RTP) following a Concussion

Player Name : \_\_\_\_\_

Assessed at time of injury by Health care professional: Yes / No

Age: \_\_\_\_\_

Assessing Practitioner (Print name ): \_\_\_\_\_

Date of Concussion: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Stage	Aim	Activity	Goal of each stage	Date:	Signed: Print Name & Designation
<b>1</b>	Symptom-limited activity A. <b>Mandatory minimum 14 days</b> following the injury for <b>ALL</b> Age group and senior players <b><u>not under the direct care of a medical practitioner.</u></b> B. Senior player, a minimum 24 hours after symptoms cleared, under the direct care of an <b><u>SRU Medical approved medical practitioner and with written clearance.</u></b>	Daily activities that do not provoke symptoms.	Gradual reintroduction of work /school activities.		
<b>2</b>	Light aerobic exercise	Walking or stationary cycling at slow to medium pace. No resistance training.	Increased heart rate.		
<b>3</b>	Sport-specific exercise	Running or skating drills. No head impact activities.	Add movement		
<b>4</b>	Non-contact training drills	Harder training drills, eg, passing drills. May start progressive resistance training	Exercise, coordination and increased thinking.		
<b>5</b>	Full contact practice	Following medical clearance, participate in normal training activities.	Restore confidence and assess functional skills by coaching staff.		
<b>6</b>	Return to play (To be assessed and signed by a Concussion Specialist Doctor)	Normal game play	Return to Sport		

**\*\* Note: An initial period of at least 48 hours of both physical and cognitive rest is mandatory before beginning the RTS Programme**

**\* Stage 1 Minimum 14 days asymptomatic .**

**\*\* Senior Players - Allow minimum 24 hours between activity levels - must be asymptomatic after each stage to progress to next stage**

**\*\* All Age Groups players (U 19's) Minimum 48hrs between activity levels- must be asymptomatic after each stage to progress to next stage**

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Doctor / Clinic Stamp

Additional Notes (If Needed)

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Signature \_\_\_\_\_

Print Name and MCR no. ....

Clinic Name and Designation .....