Trainer/Examiner – Please take a photo of this document for your records before giving it to player.

Date of Incident:		Time of Incident:	
Player's Full Name:		Player's Date of Birth:	
Club Name:		Trainer/Examiner Name:	
Trainer/Examiner Qualifications:		Trainer's Signature: The below information is the whole truth.	

Please circle the following signs and symptoms (assessed at time of head injury):

Balance problems	Drowsiness	Sensitivity to light or noise	Neck pain
Nausea or vomiting	Dizziness	Slow getting up	Difficulty concentrating
Headache	Blurred vision	Nervous or anxious	Difficulty remembering
Clutching of the head	Feeling 'foggy'	Confusion / Disorientation	Loss of consciousness

If consciousness was lost, approx. for how many minutes/seconds: _____

Other symptoms/comments:_____

_____

_____

- ☐ Has the player obtained any previous concussions, if so, record notes: _____

  _____
- ☐ Does the player participate in any other teams/sporting codes?

  If so, Club/Team name:_____
- ☐ At the time of incident, was the ambulance called to take the player to hospital?

Ask the player the following questions and assess how quickly, promptly the player answers these questions and record accordingly. Tick each question if player answers correctly.

- ☐ Where are we at today (venue)?
- ☐ Which half are we in now?
- ☐ Who scored last in this match?
- ☐ What team did you play last week?
- ☐ Did your team win the last game?
- ☐ How many concussions have you had in the past?

How did the head knock (incident) happened and why they've been taken off the field? Record answer.

_____

Player must provide this template to doctor/medical practitioner as soon as possible after the incident occurred (preferably the same day) to commence the gradual return to play process. Failure to do so, player will be subject to a mandatory 14 day stand down from any return to play procedures.

FOR DOCTOR USE ONLY

Doctor/medical practitioner – Please refer to the previous notes on this document when assessing the player and determining his/her medical fitness to return to full contact rugby league training and match competition.

CLEARANCE TO RETURN TO CONTACT TRAINING

Name of Doctor:		Signed by Doctor:	
Name of Medical Practice:		Medical Practice Address:	

*If the player has been diagnosed with a concussion, the player is to stand down from playing rugby league for 11 days if the player is aged 19 years or older, or 14 days if the player is 18 years or younger.

Was the player diagnosed with a concussion/head injury (please circle): YES NO

Comments of reassessment: _____

_____

_____

I have examined _____ (player), on _____/ _____/ _____

By signing this document, I_____ (Doctor) declare that the above player shows no signs of Delayed Concussion and in my opinion the player is now medically fit to return to full contact rugby league training and match competition.

……..

CLEARANCE TO RETURN TO FULL CONTACT MATCH COMPETITION

Name of Doctor:		Signed by Doctor:	
Name of Medical Practice:		Medical Practice Address:	

I have examined _____ (player), on _____/ _____/ _____

By signing this document, I_____ (Doctor) declare that the above player shows no signs of Delayed Concussion and in my opinion the player is now medically fit to return to full contact rugby league training and match competition.

……..

Player must return this document to a club representative once Doctor/medical practitioner has given a full clearance for player to return to full contact match competition.