Concussion Referral and Clearance Form

SECTION 2 - CLEARANCE APPROVAL
To be sent to *membership@auscycling.org.au* once completed.

TEAM OFFICIAL TO COMPLETE (Commissaire, Coach or First Aid / Healthcare practitioner*)
At the time/on the day of the injury, before presenting to healthcare practitioner reviewing the rider.

Name of rider:	Date of birth:
Sport:	Club:

Dear Healthcare Practitioner,
This person has presented to you today because they were injured on (day & date of injury) ____________
in a (competition or training session) ____________ and suffered a potential head injury or concussion.

The injury involved: (select one option)

- ☐ Direct head blow or knock
- ☐ Indirect injury to the head e.g. whiplash injury
- ☐ No specific injury observed

The subsequent signs or symptoms were observed (Please select one or more):
Consult the referee/umpire if no signs and symptoms were observed by team official personnel

- ☐ Loss of consciousness
- ☐ Dazed or vacant stare
- ☐ Ringing in the ears
- ☐ Disorientation
- ☐ Headache
- ☐ Fatigue
- ☐ Incoherent speech
- ☐ Dizziness
- ☐ Vomiting
- ☐ Confusion
- ☐ Difficulty concentrating
- ☐ Blurred vision
- ☐ Memory loss
- ☐ Sensitivity to light
- ☐ Loss of balance
- ☐ Other ____________

Is this your first known concussion in the last 12 months? ☐ Yes ☐ No

If NO, how many concussions in the last 12 months: ____________

Name: ____________ Role: ____________

Signature: ____________ Date: ____________

INJURED PERSON or PARENT / LEGAL GUARDIAN CONSENT (for persons under 18 years of age)

I ____________ (insert name) consent to ____________
(insert Healthcare Practitioner's name) providing information if required to my Club and AusCycling regarding my head injury and confirm that the information I have provided the doctor has been complete and accurate.

Name:	Signature:	Date:

Concussion Referral and Clearance Form

SECTION 2 - CLEARANCE APPROVAL

To be sent to *membership@auscycling.org.au* once completed.

I ______________________________ (healthcare practitioner's name) have reviewed ______________________________ (persons name) today and based upon the evidence presented to me by them and their family / support person, and upon my history and physical examination I can confirm:

- I have reviewed Section 1 of this form and specifically the mechanism of injury and subsequent signs and symptoms
- The person has been symptom-free for at least 14 days
- The person will not return to competition in less than 21 days from the time of concussion
- The person has completed the Graduated Return to Sport Framework process without evoking any recurrence of symptoms
- The person has returned to school, study or work normally and has no symptoms related to this activity

I also confirm that I have read the Australian Concussion Guidelines for Youth and Community Sport https://www.concussioninsport.gov.au/ data/assets/pdf_file/0003/1133994/37382_Concussion-Guidelines-for-community-and-youth-FA-acc.pdf

I therefore approve that this person may return to competition and if they successfully complete training without recurrence of symptoms, the person may return to competition.

Healthcare Practitioner's Name:

Signature: Date: