



MCKINNEY ICE HOCKEY CLUB

CONCUSSION RETURN-TO-PLAY CLEARANCE FORM

Aligned with the USA Hockey Concussion Management Program and applicable Texas youth sports concussion law

Club policy. McKinney Ice Hockey Club requires that the final medical clearance signature on this form be provided by a board-certified neurologist, or a physician with documented concussion/sports-neurology training, before a player may return to full-contact practice or competition.

Purpose & Policy

This form documents the evaluation, graduated return-to-sport progression, and medical clearance required before a McKinney Ice Hockey Club (“MKIHC” or “the Club”) player who has sustained a suspected or diagnosed concussion may return to practice or competition. It is used in conjunction with, and does not replace, USA Hockey’s “Heads Up Hockey” education program, the USA Hockey Concussion Management Program, and Texas’s youth sports concussion statute (the framework commonly referred to as Natasha’s Law, Tex. Educ. Code § 38.156 et seq. and related UIL guidance), which the Club follows as best-practice standards even where MKIHC operates outside UIL/school jurisdiction.

“When in doubt, sit them out.” Any player suspected of a concussion must be removed from play immediately and may not return the same day, regardless of how the player appears or claims to feel.

Removal From Play: Signs & Symptoms Checklist

To be completed by the coach, team safety volunteer, or on-ice official who removed the player from play. Check all that were observed or reported.

- ☐ Loss of consciousness, even briefly
- ☐ Lying motionless on the ice / slow to get up
- ☐ Balance problems, stumbling, or clumsy movement
- ☐ Disorientation, confusion, or vacant/dazed expression
- ☐ Blank or vacant stare; inappropriate or slowed responses to questions
- ☐ Headache or “pressure” in the head
- ☐ Nausea or vomiting
- ☐ Dizziness or blurred/double vision
- ☐ Sensitivity to light or noise
- ☐ Amnesia for the event or surrounding events
- ☐ Emotional changes (irritability, sadness, unusual behavior)
- ☐ Other (describe below)

If other, describe: _____

Player & Incident Information

Player full name: _____ Date of birth: _____

Team / age classification: _____ Jersey #: _____

Date of injury: _____ Approximate time: _____

Location / event (rink, game, or practice): _____

Description of how the injury occurred: _____

Name & role of person who removed player from play: _____

Parent/guardian notified? ☐ Yes ☐ No Emergency care sought? ☐ Yes ☐ No

This athlete has been evaluated by a neuropsychologist and/or physician (MD/DO). Neuropsychologist and/or physician determined: (select all that apply)

☐ No concussion diagnosed and no follow up needed. **Athlete CLEARED to return to full participation.**

☐ Concussion diagnosed, athlete is actively symptomatic, and not ready to start the Return to Play Protocol. **Athlete NOT CLEARED to return to full participation.** Visit Date: _____

☐ Concussion was diagnosed, athlete not actively symptomatic, and ready to start the Return to Play Protocol. **Athlete NOT CLEARED to return to full participation.** Visit Date: _____

Step 1: Graduated Return-to-Sport Protocol

Per the USA Hockey Concussion Management Program, the player must complete an initial 24-48 hour period of relative rest, then progress through the following stages. Each stage requires a minimum of 24 hours, and the player must remain completely symptom-free at rest and with exertion before advancing to the next stage. Any return of symptoms requires the player to stop, rest until symptoms resolve, and resume at the last symptom-free stage. Stages 5 and 6 may not begin until the medical clearance in Section 6 has been obtained.

Stage	Focus	Activity	Date completed / initials
1	Symptom-limited activity	Ordinary daily activities that do not worsen symptoms (e.g., walking, schoolwork).	
2	Light aerobic exercise	Light to moderate stationary cycling or walking; light resistance training. No head-impact risk.	
3	Sport-specific exercise	Individual on-ice or off-ice skating/skill drills, no contact and no head-impact risk.	
4	Non-contact training drills	Higher-intensity individual and team drills; may resume light resistance training. Still no contact.	
5	Full-contact practice	Normal training activities following medical clearance (see Section 6).	
6	Return to competition	Unrestricted game play.	

**Completion of accepted return to play protocol should be under the guidance of your treating physician or neuropsychologist.*

Step 2: Medical Evaluation & Required Neurologist Clearance

Before advancing to Stage 5 (full-contact practice), the player must be evaluated in person by a licensed physician and receive written clearance on this form. Consistent with McKinney Ice Hockey Club policy, the clearing physician must be a board-certified neurologist, or a physician with documented training/certification in concussion management or sports neurology. A note from a non-specialist (e.g., urgent care or primary care) may support interim steps but does not satisfy this Club's final clearance requirement.

Date of medical evaluation: _____

Diagnosis / clinical findings: _____

Imaging or additional testing performed (if any): _____

- ☐ Player has been symptom-free at rest and with physical/cognitive exertion for at least 24 hours
- ☐ Player has successfully completed Stages 1–4 of the graduated return-to-sport protocol above
- ☐ Player is cleared for Stage 5 (full-contact practice) and Stage 6 (return to competition) without restriction

Physician / Neurologist Certification

Physician name (printed): _____

Medical license #: _____

Board certification / specialty: _____

Practice / clinic name: _____

Practice address & phone: _____

I certify that I have personally examined the above-named player, that the player is free of concussion-related signs and symptoms, and that the player is cleared for full, unrestricted participation in hockey activities, including full-contact practice and competition, effective the date below.

Physician signature: _____ **Date:** _____

Acknowledgment & Authorization Signatures

All three signatures below are required before the player may resume Club activities.

Parent / Legal Guardian

I have read the physician's clearance above, understand the signs and symptoms of concussion, and authorize my child's unrestricted return to McKinney Ice Hockey Club practices and games.

Parent/guardian name (printed): _____

Relationship to player: _____

Signature: _____

Date: _____

Head Coach / Team Manager

I acknowledge receipt of this completed form, including physician clearance and parent/guardian authorization, prior to the player's return to full-contact practice or competition.

Name (printed): _____

Team: _____

Signature: _____

Date: _____

Club Safety Coordinator / Director of Hockey Operations

This completed form has been reviewed and filed in the player's Club safety record.

Name (printed): _____

Title: _____

Signature: _____

Date: _____

This form must be retained in the player's confidential file with the Club Safety Coordinator for the duration of the player's membership plus the period required by USA Hockey and Texas record-retention practice. This form is not a substitute for emergency medical care, if a player shows any "red flag" symptom (worsening headache, repeated vomiting, seizure, weakness/numbness, slurred speech, or increasing confusion), call 911 immediately.

Email this completed form to safety@mckinneyicehockey.org

NOTE: DO NOT SUBMIT THIS FORM UNTIL TOTALLY CLEARED TO RETURN TO FULL COMPETITION