Oracle Elementary School District

Junior High School Athletics Participation Guidelines

Mountain Vista K-8 School is a member of the Central Junior High Athletic League. The conference is a competitive conference including a one day system of playoffs and a championship in both the seventh and eighth grades. Mountain Vista K-8 School currently offers six official school athletic programs:

Season 1 starts at the beginning of the school year and ends mid-October:

- Flag Football
- Girls Volleyball

Season 2 starts after season 1 and ends at the end of January:

- Wrestling
- Boys and Girls Basketball

Season 3 starts after season 2 and ends mid-April:

- Track and field
- Girls Softball
- Boys Baseball

1. Student participation in each season:

- Team sports, excluding track and field and wrestling, will have a participation cap. If the cap is exceeded there will be a tryout system to meet the participation cap. This is necessary to avoid teams having too many participants to properly teach the fundamentals of the sport and allow for adequate playing time during the conference games. There are many years when the caps are not met. It is the desire of the Oracle Elementary School District that the tryout system is a last resort when participation numbers are higher than we are able to manage in a fair and consistent manner. The District also offers a developmental community schools athletics program that includes: basketball, flag football and soccer.

2. Participation Caps: If participation caps are utilized for a season, students that come in after teams have been determined will not be permitted to participate until the next season.

- Flag Football:
  Combined grades 7 and 8: **50 Athletes**
- Girls Volleyball:
  Grade 6: **6 Athletes on a no fee, developmental basis**
  Grade 7: **12 athletes**
  Grade 8: **12 athletes**
- Wrestling: **No cap**
- Boys and Girls Basketball:
  Grade 7: **12 athletes**
  Grade 8: **12 athletes**

***Grade 6 athletes may try out for the team if there are less than 12 seventh grade athletes.**

- Track and field: **No cap**
- Girls Softball:
  Combined grades 7 and 8: **15 athletes**
  ***Coaches may tryout and keep three sixth grade athletes in addition to the 15 grade 7 and 8 athletes.**
- Boys Baseball:
  Combined grades 7 and 8: **15 athletes**
  ***Coaches may tryout and keep three sixth grade athletes in addition to the 15 grade 7 and 8 athletes.**

3. Playing time:

- Playing time often varies depending on the level of the competition. Coaches will make every effort to ensure that throughout the season participants get the opportunity to play meaningful periods of time during league competition. Because of varying skill levels and player experience playing time will not necessarily be equal. Coaches will monitor playing time to ensure that players do get opportunities to play during the season. If a parent is concerned about playing time, they are welcome to voice their concerns to the coach but not on the day of the game. All concerns that are not immediately related to a player's safety must be addresses utilizing the procedures outlined in the **Students-Athlete-Contract**. This procedure allows for the coaches to manage their many responsibilities on game day and will ensure that all concerns are discussed in a meaningful and productive manner. If resolution to a concern is not reached, please use the "parent concern form" which should be submitted to the athletic director through the Mountain Vista Office.
- During the one day championship tournament, playing time will likely be limited as the team progresses through the bracket.
- All coaches have the right to limit playing time as a consequence for poor behavior, academic deficiencies and missed practices.

Student-Athlete Agreement

Purpose:
This athletic agreement has been established to explain and to inform athletes, parents, and coaches of specific expectations relative to participation in interscholastic athletes, softball, at Mountain Vista K-8 School (MVS).

Conduct
All MVS student-athletes are expected to adhere to the rules and responsibilities as outlined by the school and coach. Athletes are expected to understand that incidents of misconduct in or out of school may have a definite effect on participation on the softball team. Areas of concern, such as, but not all inclusive are:

a) tobacco use in any form,
b) alcohol use in any form,
c) use of drugs: depressants, stimulants, or any controlled substance.
d) use of performance enhancing drugs,
e) verbal or physical harassment,
f) sexual harassment,
g) theft and vandalism
h) behaviors that increase the likelihood for the spread of illness including coming to practice or a game while sick, not covering one's mouth when sneezing or coughing, coming to practice or a game in an unwashed uniform or practice clothes, spitting.

An athlete may be suspended for part or ALL of the season for demonstrating behavior that is detrimental to the team. Suspensions will be handled on an individual basis. What is best for the team, first and foremost, and then what is best for the individual athlete will be the approach of the Athletic Department.

Academics
All MVS student-athletes are required to maintain at least a 60% GPA, preferably higher, practice regular attendance to classes, and cannot receive a letter grade of F. If a player's GPA is lower than the above specified or she has received an F, they will be suspended from play until their academics have improved. We need our athletes to be successful in the classroom and on the field.

Protocol to discuss concerns with Coaching Staff
We are here to serve you and your student athlete. The following is the protocol we expect each parent/guardian to abide by:

1. Have the student-athlete discuss any issues/concerns with the Coach. If this does not resolve the problem, proceed to #2.

2. Parent/guardian may call the Coach directly to set up a meeting day & time to discuss any concerns pertaining to his/her child. Please DO NOT approach the Coach before, during or after a game OR practice to discuss a concern unless the concern is an immediate emergency to the team.
3. If you are not satisfied with the outcome of your meeting, please contact the Athletic Director, Greg Reiser @ 896-3022.

Student signature_____Date_____

Parent/guardian signature_____Date_____

MOUNTAIN VISTA
COUGARS

Emergency Information
And Medical Release Form
Mt. Vista Athletics Participation
Oracle School District #2

Student Name: _____ Grade _____

Birthdate _____ Age____ Home Phone _____

Parent's (Guardian's) Name(s)_____

E-mail Address: _____

Mother Cell or Work _____Father Cell or Work_____

In an emergency, if parents cannot be contacted:

Notify _____ at _____

Family Doctor _____ Doctor's Phone _____

Insurance Company _____
Preferred Hospital _____ Known Allergies _____

The coach or assistant coach may apply first aid treatment until the family doctor can be contacted. Yes ___ No ____
Any other information on health the coaches should know: _____

_____ has my permission to participate in interscholastics. This includes all sports for the entire school year. Practice will generally be from 3:45 to 5:45 each day.

Medical Release

I realize that the District's liability coverage only applies to injury if negligence is proven against the District and the terms and conditions of the contractual liability coverage provided in favor of the District have been met; in all other circumstances, the student's health insurance will provide coverage for the student's injuries. In case of accident or serious illness, I request the school/coach to contact me. If I cannot be reached, I hereby authorize the school/coach to call the physician indicated above and follow his or her instructions. If it is impossible to contact the parent or physician, the school/coach may make whatever arrangements necessary to secure medical aid and ambulance service. I have legal custody or control of my child and grant permission for any emergency treatment and/or hospital services rendered to said minor.

_____ _____
Parent Printed Name Date

_____ _____
Parent Signature Home Address

ARIZONA INTERSCHOLASTIC ASSOCIATION
7007 N. 18TH ST., PHOENIX, ARIZONA 85020-5552
PHONE: (602) 385-3810

2021-22 ANNUAL PREPARTICIPATION PHYSICAL EVALUATION

(The parent or guardian should fill out this form with assistance from the student-athlete) Exam Date: _____

Name: _____
Home Address: _____
Phone: _____
Date of Birth: _____
Age: _____
Gender: _____
Grade: _____
School: _____
Sport(s): _____
Personal Physician: _____
Hospital Preference: _____

In case of emergency contact:
Name: _____
Relationship: _____
Phone (Home): _____
Phone (Work): _____
Phone (Cell): _____

Name: _____
Relationship: _____
Phone (Home): _____
Phone (Work): _____
Phone (Cell): _____

Explain "Yes" answers on the following page.
Circle questions you don't know the answers to.

	Y	N
1) Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2) Do you have an ongoing medical conditional (like diabetes or asthma)?	☐	☐
3) Are you currently taking any prescription or nonprescription (over-the-counter) medicines or supplements? (Please specify): _____	☐	☐
4) Do you have allergies to medicines, pollens, foods or stringing insects? (Please specify): _____	☐	☐
5) Does your heart race or skip beats during exercise?	☐	☐
6) Has a doctor ever told you that you have (check all that apply): ☐ High Blood Pressure ☐ A Heart Murmur ☐ High Cholesterol ☐ A Heart Infection		
7) Have you ever spent the night in a hospital?	☐	☐
8) Have you ever had surgery?	☐	☐
9) Have you ever had an injury (sprain, muscle/ligament tear, tendinitis, etc.) that caused you to miss a practice or game? (If yes, check affected area in the box below in question 11)	☐	☐
10) Have you had any broken/fractured bones or dislocated joints? (If yes, check affected area in the box below in question 11):	☐	☐
11) Have you had a bone/joint injury that required X-rays, MRI, CT, surgery, injections, rehabilitation physical therapy, a brace, a cast or crutches? (If yes, check affected area in the box below):	☐	☐

☐ Head ☐ Neck ☐ Shoulder ☐ Upper Arm ☐ Elbow ☐ Forearm
☐ Hand/Fingers ☐ Chest ☐ Upper Back ☐ Lower Back ☐ Hip ☐ Thigh
☐ Knee ☐ Calf/Shin ☐ Ankle ☐ Foot/Toes

	Y	N
12) Have you ever had a stress fracture?	☐	☐
13) Have you ever been told that you have, or have you had an X-ray for atlantoaxial (neck) instability?	☐	☐
14) Do you regularly use a brace or assistive device?	☐	☐
15) Has a doctor told you that you have asthma or allergies?	☐	☐
16) Do you cough, wheeze or have difficulty breathing during or after exercise?	☐	☐
17) Is there anyone in your family who has asthma?	☐	☐
18) Have you ever used an inhaler or taken asthma medication?	☐	☐
19) Were you born without, are you missing, or do you have a nonfunctioning kidney, eye, testicle or any other organ?	☐	☐
20) Have you had infectious mononucleosis (mono) within the last month?	☐	☐
21) Do you have any rashes, pressure sores or other skin problems?	☐	☐
22) Have you had a herpes skin infection?	☐	☐
23) Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or headache from a hit to your head, having your "bell rung" or getting "dinged")?	☐	☐
24) Have you ever had a seizure?	☐	☐
25) Have you ever had numbness, tingling or weakness in your arms or legs after being hit, falling, stingers or burners?	☐	☐
26) While exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
27) Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
28) Have you ever been tested for sickle cell trait?	☐	☐
29) Have you had any problems with your eyes or vision?	☐	☐
30) Do you wear glasses or contact lenses?	☐	☐
31) Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
32) Are you happy with your weight?	☐	☐
33) Are you trying to gain or lose weight?	☐	☐
34) Has anyone recommended you change your weight or eating habits?	☐	☐
35) Do you limit or carefully control what you eat?	☐	☐
36) Do you have any concerns that you would like to discuss with a doctor?	☐	☐

Females Only

	Y	N
37) Have you ever had a menstrual period?	☐	☐
38) How old were you when you had your first menstrual period?	_____	
39) How many periods have you had in the last year?	_____	

Explain "Yes" Answers Here

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PHONE: (602) 385-3810

2021-22 ANNUAL PREPARTICIPATION PHYSICAL EXAMINATION

The physician should fill out this form with assistance from the parent or guardian.)

Student Name: _____ Date of Birth: _____

Patient History Questions: Please Tell Me About Your Child...

		Y	N
1)	Has your child fainted or passed out DURING or AFTER exercise, emotion or startle?	☐	☐
2)	Has your child ever had extreme shortness of breath during exercise?	☐	☐
3)	Has your child had extreme fatigue associated with exercise (different from other children)?	☐	☐
4)	Has your child ever had discomfort, pain or pressure in his/her chest during exercise?	☐	☐
5)	Has a doctor ever ordered a test for your child's heart?	☐	☐
6)	Has your child ever been diagnosed with an unexplained seizure disorder?	☐	☐
7)	Has your child ever been diagnosed with exercise-induced asthma not well controlled with medication?	☐	☐

Explain "Yes" Answers Here

COVID-19...

		Y	N
1)	Has your child been diagnosed with COVID-19?	☐	☐
	1a) If yes, is your child still having symptoms from their COVID-19 infection?	☐	☐
2)	Was your child hospitalized as a result for complications of COVID-19?	☐	☐
3)	Has your child been diagnosed with Multi-Inflammatory Syndrome in Children (MIS-C)?	☐	☐
4)	Did your child have any special tests ordered for their heart or lungs or were referred to a heart specialist (cardiologist) to be cleared to return to sports?	☐	☐
5)	Has your child returned back to full participation in sports?	☐	☐
6)	Has your child had direct or known exposure to someone diagnosed with COVID-19 in the past 3 months?	☐	☐
	6a) Was your child tested for COVID-19?	☐	☐
7)	Did your child receive the COVID-19 vaccine?	☐	☐

7a) What was the manufacturer of the vaccine? _____

7b) Date of vaccination(s) _____

Explain "Yes" Answers Here

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Family History Questions: Please Tell Me About Any Of The Following In Your Family...

		Y	N
1)	Are there any family members who had sudden/unexpected/unexplained death before age 50? (including SIDS, car accidents drowning or near drowning)	☐	☐
2)	Are there any family members who died suddenly of "heart problems" before age 50?	☐	☐
3)	Are there any family members who have unexplained fainting or seizures?	☐	☐
4)	Are there any relatives with certain conditions, such as:		

	Y	N		Y	N
Enlarged Heart	☐	☐	Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)	☐	☐
Hypertrophic Cardiomyopathy (HCM)	☐	☐	Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	☐	☐
Dilated Cardiomyopathy (DCM)	☐	☐	Marfan Syndrome (Aortic Rupture)	☐	☐
Heart Rhythm Problems	☐	☐	Heart Attack, Age 50 or Younger	☐	☐
Long QT Syndrome (LQTS)	☐	☐	Pacemaker or Implanted Defibrillator	☐	☐
Short QT Syndrome	☐	☐	Deaf at Birth	☐	☐
Brugada Syndrome	☐	☐			

Explain "Yes" Answers Here

I hereby state that, to the best of my knowledge, my answers to all of the above questions are complete and correct. Furthermore, I acknowledge and understand that my eligibility may be revoked if I have not given truthful and accurate information in response to the above questions.

Signature of Student-Athlete _____ Signature of Parent/Guardian _____ Date _____

Signature of MD/DO/ND/NMD/NP/PA-C/CCSP _____ Date _____

AIA ARIZONA INTERSCHOLASTIC ASSOCIATION™

OUR STUDENTS, OUR TEAMS . . . OUR FUTURE.

Arizona Interscholastic Association, Inc.
Mild Traumatic Brain Injury (MTBI) / Concussion
Annual Statement and Acknowledgement Form

I, _____ (student), acknowledge that I have to be an active participant in my own health and have the direct responsibility for reporting all of my injuries and illnesses to the school staff (e.g., coaches, team physicians, athletic training staff). I further recognize that my physical condition is dependent upon providing an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced before, during or after athletic activities.

By signing below, I acknowledge:

- My institution has provided me with specific educational materials including the CDC Concussion fact sheet (http://www.cdc.gov/concussion/HeadsUp/youth.html) on what a concussion is and has given me an opportunity to ask questions.
- I have fully disclosed to the staff any prior medical conditions and will also disclose any future conditions.
- There is a possibility that participation in my sport may result in a head injury and/or concussion. In rare cases, these concussions can cause permanent brain damage, and even death.
- A concussion is a brain injury, which I am responsible for reporting to the team physician or athletic trainer.
- A concussion can affect my ability to perform everyday activities, and affect my reaction time, balance, sleep, and classroom performance.
- Some of the symptoms of concussion may be noticed right away while other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I am responsible for reporting the injury to the school staff.
- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
- I will not return to play in a game or practice until my symptoms have resolved AND I have written clearance to do so by a qualified health care professional.
- Following concussion the brain needs time to heal and you are much more likely to have a repeat concussion or further damage if you return to play before your symptoms resolve.

Based on the incidence of concussion as published by the CDC the following sports have been identified as high risk for concussion; baseball, basketball, diving, football, pole vaulting, soccer, softball, spiritline and wrestling.

I represent and certify that I and my parent/guardian have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be bound by this document.

Student Athlete:
Print Name: _____ Signature: _____ Date: _____

Parent or legal guardian must print and sign name below and indicate date signed:
Print Name: _____ Signature: _____ Date: _____

A FACT SHEET FOR

Athletes

CDC HEADS UP
SAFE BRAIN. STRONGER FUTURE.

This sheet has information to help you protect yourself from concussion or other serious brain injury and know what to do if a concussion occurs.

WHAT IS A CONCUSSION?

A concussion is a brain injury that affects how your brain works. It can happen when your brain gets bounced around in your skull after a fall or hit to the head.

What Should I Do If I Think I Have a Concussion?

Report It.

Tell your coach and parent if you think you or one of your teammates may have a concussion. You won't play your best if you are not feeling well, and playing with a concussion is dangerous. Encourage your teammates to also report their symptoms.

Get Checked Out by a Doctor.

If you think you have a concussion, do not return to play on the day of the injury. Only a doctor or other healthcare provider can tell whether you have a concussion and when it's OK to return to school and play.

Give Your Brain Time to Heal.

Most athletes with a concussion get better within a couple of weeks. For some, a concussion can make everyday activities, such as going to school, harder. You may need extra help getting back to your normal activities. Be sure to update your parents and doctor about how you are feeling.

GOOD TEAMMATES KNOW:

IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON.

cdc.gov/HEADSUP

How Can I Tell If I Have a Concussion?

You may have a concussion if you have any of these symptoms after a bump, blow, or jolt to the head or body:

- **Get a headache**
- **Feel dizzy, sluggish, or foggy**
- **Are bothered by light or noise**
- **Have double or blurry vision**
- **Vomit or feel sick to your stomach**
- **Have trouble focusing or problems remembering**
- **Feel more emotional or "down"**
- **Feel confused**
- **Have problems with sleep**

A concussion feels different to each person, so it's important to tell your parents and doctor how you feel. You might notice concussion symptoms right away, but sometimes it takes hours or days until you notice that something isn't right.

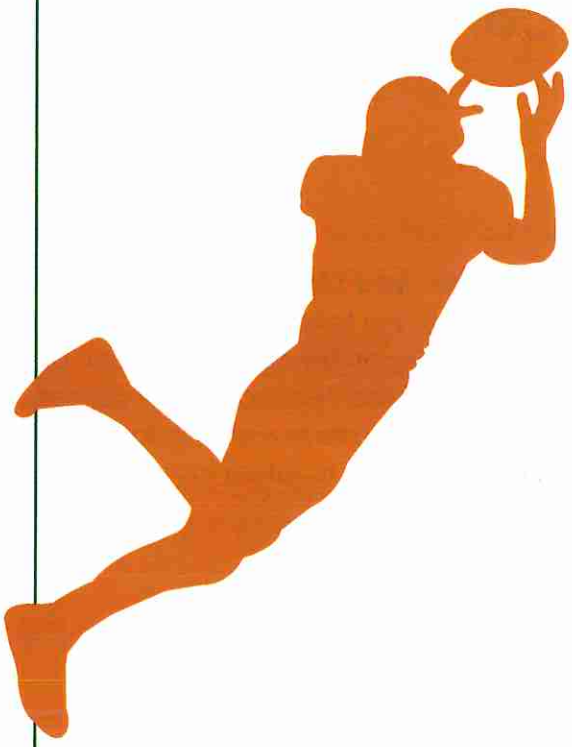
How Can I Help My Team?

Protect Your Brain.

All your teammates should avoid hits to the head and follow the rules for safe play to lower chances of getting a concussion.

Be a Team Player.

If one of your teammates has a concussion, tell them that they're an important part of the team and they should take the time they need to get better.



The information provided in this document or through linkages to other sites is not a substitute for medical or professional care. Questions about diagnosis and treatment for concussion should be directed to a physician or other healthcare provider.

Revised January 2019

To learn more, go to cdc.gov/HEADSUP

CDC HEADS UP

CONCUSSION IN YOUTH SPORTS

Information for Parents

CDC HEADS UP

SAFE BRAIN. STRONGER FUTURE.

SIGNS & SYMPTOMS

If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs and symptoms of a concussion:

SIGNS OBSERVED BY PARENTS OR GUARDIANS

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets sports plays
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows behavior or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

SYMPTOMS REPORTED BY THE ATHLETE

- Headache or "pressure" in the head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Does not "feel right"

IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON.

CDC

January 2021

WHAT SHOULD YOU DO IF YOU THINK YOUR CHILD HAD A CONCUSSION?

1. **Seek medical attention right away.** A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to sports.
2. **Keep your child out of play.** Concussions take time to heal. Don't let your child return to play until a health care professional says it's OK. Children who return to play too soon—while the brain is still healing—risk a greater chance of having a second concussion. Second or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.
3. **Tell your child's coach about any recent concussion.** Coaches should know if your child had a recent concussion. Your child's coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

IMPORTANT PHONE NUMBERS

FILL IN THE NAME AND NUMBER OF YOUR LOCAL HOSPITAL(S) BELOW:

Hospital Name: _____

Hospital Phone: _____

Hospital Name: _____

Hospital Phone: _____

For immediate attention, CALL 911

For more information, visit **www.cdc.gov/HEADSUP**

Oracle School District Athletic Program Parent Concern Form

This form is only to be utilized after the parent/guardian has spoken with the coach per the guidelines outlined in the Student-Athlete Contract.

1. **Name of person submitting the concern:**_____

2. **Date the form was submitted:**_____

3. **Contact information:**

   -Phone Number:_____

   -Cell Phone Number_____

   -Email address:_____

4. **Please state the nature of your concern and measures you have already taken to have the issue resolved.**

_____
_____
_____
_____
_____
_____
_____
_____

*This section is to be filled out by the athletic director.

a. Action taken to resolve the issue:_____
_____
_____
_____
_____

b. Form of follow-up contact with the parent and comments regarding the follow-up:_____
_____
_____
_____
_____

AIA COVID-19 Return to Play Form

If an athlete has tested positive for COVID-19, has had a close contact with an individual who has COVID-19 and develops symptoms but was not tested, or was placed on self-isolation and did not develop symptoms, the athlete must be cleared for progression back to activity by a qualified medical provider. Individuals who have had COVID-19 are at risk of developing severe cardiac complications that can affect participation in sport. There is limited research in this area particularly in youth athletes to standardize clinical decision making. For these reasons, it is strongly recommended that this form be completed by the patient's primary care provider. Evaluation and management by the primary care provider allows for the patient's past medical and cardiac history to be known.

Name: _____ DOB: _____ Date of Positive PCR Test: _____

THIS RETURN TO PLAY IS BASED ON TODAY'S EVALUATION

Date of Evaluation: _____

Date symptoms started_____ Date of last fever (≥100.4F) _____

Criteria to return (Please check below as applies)

- ❑ Symptoms are resolved or nearly resolved, any remaining symptoms are not interfering with daily activities without medication
- ❑ No fever (≥100.4F) for minimum of 14 days without fever reducing medication
- ❑ COVID-19 respiratory and cardiac symptoms (moderate/severe cough, shortness of breath, fatigue) have resolved
- ❑ Athlete was not hospitalized due to COVID-19 infection.
- ❑ Cardiac screen negative for myocarditis/myocardial ischemia (All answers below must be no)

Chest pain/tightness with daily activities	YES ❑ NO ❑
Unexplained Syncope/near syncope	YES ❑ NO ❑
Unexplained/excessive dyspnea/fatigue w/ daily activities	YES ❑ NO ❑
New palpitations	YES ❑ NO ❑
Heart murmur on exam	YES ❑ NO ❑

NOTE: If any cardiac screening question is positive or if athlete was hospitalized, had prolonged fevers (greater than 3 days) or was diagnosed with multisystem inflammatory syndrome in children (MIS-C), further workup is recommended based on the Return to Play After COVID-19 Infection in Pediatric Patients Clinical Pathway.

- ❑ I am familiar and have reviewed the athletes past medical, social, cardiac, and family history and have no concerns with the athlete starting a return to play progression.
- ❑ Athlete HAS satisfied the above criteria and IS cleared to start the return to activity progression.
- ❑ Athlete HAS NOT satisfied the above criteria and IS NOT cleared to return to activity

Medical Office Information (Please Print/Stamp):
Recommended: Primary Care Physician or MD/DO

Evaluator's Name: _____ Office Phone: _____

Evaluator's Address: _____

Evaluator's Signature: _____

Return to Play (RTP) Procedures After COVID-19 Infection

Athletes must complete the progression below, under the supervision of the athletic trainer or other school personnel, without development of chest pain, chest tightness, palpitations, lightheadedness, pre-syncope or syncope. If these symptoms develop, patient should be referred back to the evaluating provider who signed the form.

Stage	Timing	Activities
Stage 1	2 days minimum	Light activity for 15 minutes or less at an intensity no greater than 70% of maximum heart rate (eg. walking, jogging, stationary bike). No resistance training
Stage 2	1 day minimum	Light activity with simple movement activities (eg. running drills) for 30 minutes or less at an intensity no greater than 80% maximum heart rate. No resistance training
Stage 3	1 day minimum	Progress to more complex training for 45 minutes or less at an intensity of no greater than 80% maximum heart rate. May add light resistance training.
Stage 4	2 days minimum	Normal training activity for 60 minutes or less at an intensity no greater than 80% maximum heart rate
Stage 5		Return to full activity

Cleared for Full Participation by School Personnel (Minimum 7 days spent on RTP): _____

RTP Procedure adapted from Elliott N, et al. Infographic. British Journal of Sports Medicine, 2020