Concussion Return to Play Form

Student:_____ Gender: □ Female □Male

Date of Birth:_____ Grade Level: _____

Date of Injury:_____Activity: _____

Date of Initial Exam: _____

After consultation and examination, the above named student is released to return to activities as indicated below. Restrictions to participation, if any, are as noted.

☐ Student may return to practice on the following date: _____

☐ Student may return to full participation on the following date: _____

☐ Restrictions: _____

_____

_____

_____

_____

Physician's Signature / Date

Physician's Name: _____

Office Address: _____

Office Phone: _____

By signature below, I agree that the above named student may return to participation as indicated above.

_____ _____

Parent/Guardian Signature Date