Texas Association of Private and Parochial Schools

Concussion Return to Play Form

Student: ____________ **Date of Birth:** ____________

Gender: ☐Female ☐Male **Grade Level:** ☐9th ☐10th ☐11th ☐12th

School (City/School): ____________

Date of Injury: ____________ **Activity:** ____________

Date of Initial Exam: ____________

After consultation and examination, the above named student is released to return to activities as checked 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:**

____

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____

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**