DAVIS SCHOOL DISTRICT
Athlete & Student Concussion and Traumatic Head Injury
Managing Health Care Provider Statement

Patient/Student_____ School of Attendance_____

The above named patient/student is under my care for the treatment of a concussion or traumatic head injury.

1. I certify this patient/student is medically cleared and ready to progress back to full activity in the following sporting event(s) _____
_____
_____

2. Additional recommendations, if any_____
_____
_____

3. I certify that within the three years before the day on which this statement is signed, I have successfully completed a continuing education course in the evaluation and management of a concussion or traumatic head injury.

Managing Health Care Provider

Name of Provider_____ Office Address_____

Office Phone:_____ Alternate Phone:_____ E-mail_____

_____ _____
Signature Date

"Sporting event" means any of the following athletic activities that is organized, operated, managed, or sponsored by the District (i) a game; (ii) a practice; (iii) a sports camp; (iv) a physical education classes; (v) a competition; or (vi) a tryout.