St. Mary's Ryken

A College Preparatory Catholic High School

Concussion Clearance Form

Name: ______________________________ Date of Injury: ____________

Based on our observations and/or incident described below, we believe this student-athlete exhibited signs and symptoms of a concussion while participating in __________________. This student-athlete has been evaluated by a health care professional at school (certified athletic trainer) trained in recognizing and treating concussions.

Description of Incident/Injury:____

____

Athletic Trainer:____ Date:________________

Directions: Provide this form to the health care provider evaluating the student-athlete's injury. Return this form to the certified athletic trainer at St. Mary's Ryken High School once the health care provider has **cleared** the student-athlete for return to play and/or graduated return to play status. This form **must** be turned into the certified athletic trainer prior to any participation in any school related sporting events (i.e., practice, lifting, scrimmages, games, conditioning).

Medical Facility Name: _______________________________ Phone: __________________

Physicians Stamp

Diagnosis:

☐ The student-athlete sustained a concussion

☐ No significant injury, may immediately resume all activities without restrictions

Date student-athlete may return to play: __________________ Graduated Return to Play Y / N

Physician Notes: ____

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Physician Signature: ______________________________________ Date:________________

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