MORRIS SCHOOL DISTRICT
HEALTH SERVICES

CONCUSSION RELEASE/CLEARANCE
FOR STUDENT-ATHLETES

Date _______________

STUDENT-ATHLETE'S NAME ____

SCHOOL ____ LASID # ____________________________

TO BE COMPLETED BY THE STUDENT-ATHLETE'S HEALTH CARE PROVIDER

STUDENT-ATHLETE MUST RETURN THE COMPLETED FORM TO THE ATHLETIC TRAINER OR SCHOOL NURSE.

I certify that I have been trained in the evaluation and management of concussion to determine the presence or absence of a sports-related concussion or head injury.

I have examined the above-name student-athlete. My medical examination has determined the following: (Please check one of the boxes below.)

- ☐ **1. This injury IS NOT a concussion or other head injury**. The student-athlete is asymptomatic at rest. Therefore, he/she may return to the interscholastic athletic activity, as well as physical education classes.

- ☐ **2. This injury IS a concussion or other head injury**. The student is **symptomatic at rest**. Therefore, he/she may **NOT** begin the graduated return to competition and practice protocol. He/she will also not be allowed to participate in physical education classes.

- ☐ **3. This injury is a concussion or other head injury**. The student is **asymptomatic at rest**. Therefore, he/she can begin the graduated return to competition and practice protocol. He/she will not be allowed to participate in sports or physical education until that protocol has been completed successfully.

For concussions, please also complete the attached Post-Concussion Return to Academic classes for Student Athletes.

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Health Care Provider's signature

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Date

Health Care Provider's stamp

TO BE SIGNED BY THE SCHOOL, CONTRACTED, OR TEAM PHYSICIAN IF #3 ABOVE IS CHECKED.

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School, Contracted, or Team Physician's signature

12/20/2011, revised 4/14/2013, 7/12/13