



New Providence High School

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Lauren Zirpoli, Principal
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"Dedicated to Excellence"

CONCUSSION RETURN-TO-PLAY CLEARANCE

Patient Name: _____

Date: _____

Please check and date ONE option below:

The athlete named above is cleared to start the graduated, individualized return to competition and practice protocol as of _____. If the athlete successfully completes the protocol without re-emergence of any signs or symptoms of a concussion, he/she may return to full contact sports participation immediately thereafter.

OR

The athlete named above **has completed** a graduated, individualized return to practice and competition protocol and is cleared for a complete return to full contact sport participation as of _____.

The athlete is instructed to stop play immediately and notify the coach or athletic trainer should his/her symptoms return.

I hereby certify that I have received training in the evaluation and management of concussions.
(N.J.S.A. 18A:40-41, 4)

Printed Name of Physician: _____ Phone: _____

Physician Signature: _____

Address or Stamp: _____