NEW PROVIDENCE HIGH SCHOOL
ATHLETICS
35 Pioneer Drive, New Providence, NJ 07974 (908)464-4700

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: _____