



St. Mary's Ryken

A College Preparatory Catholic High School

Concussion Clearance Form

Name: _____

Date of Injury: _____

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

Description of injury/incident: _____

Athletic Trainer: _____

Date: _____

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

Medical Facility Name: _____

Phone: _____

Diagnosis:

Physician Stamp

____ 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

Physicians Notes: _____

Physician Signature: _____

Date: _____