MEDICAL RELEASE FOR RETURN TO ATHLETIC PARTICIPATION FOLLOWING A CONCUSSION

Please print. Once completed, the original form should be sent to the attention of Mary Ann King, Athletic Administrator and a copy is to be retained by the member Athletic Director.

Team Name: ___________________________ Team City: ___________________________

This release is to certify that ___________________________ has been examined due to experiencing the signs, symptoms and behaviors consistent with a concussion. Following an examination, it is my medical opinion that he/she:

_____ Is unable to return to any participation in athletics until further notice. Return appointment scheduled on: ___________________________ (Date)

_____ May return to limited participation in athletics on: ___________________________ (Limitations are noted below) (Date)

_____ May return to limited participation and this student needs to return for re-evaluation before being released for full participation in athletics. (Limitations are noted below)

_____ May return to full participation in athletics on: ___________________________ (Date)

Limitations:

________________________________________________________________________

________________________________________________________________________

Health Care Provider’s Name (Type or print) ___________________________ Date

Health Care Provider’s Signature ___________________________ Phone Number

Parent’s or Guardian’s Consent

I hereby give my consent for my son/daughter to return to participation following his/her concussion as per the instructions detailed above.

_________________________________________ ___________________________

Parent’s or Guardian’s Signature Date

_________________________________________ ___________________________

Parent’s or Guardian’s Cell Phone Parent’s or Guardian’s Work Phone

Rev. 4/2/18