Medical Clearance to Return to Play Following Concussion
(must be completed by a physician/practitioner prior to returning to practice or race)

Athlete Name: _____ DOB: ____ /____ /____

School: _____ Date of Injury: ____ /____ /____

I have seen and evaluated the above athlete and feel it is safe for them to begin physical activity following the graduated return to play guidelines. They should not participate in unrestricted physical activity until symptom free at rest and with exertion. This athlete has the following additional restrictions: _____

_____

Signature: _____ Date: _____

Printed Name: _____ Title: _____

Clinic Name: _____

Clinic Address/Phone: _____

_____