MEDICAL RELEASE FOR RETURN TO ATHLETIC PARTICIPATION FOLLOWING A CONCUSSION

Please Print. Once completed, the original form should be sent to the attention of Christopher Farroni, Athletic Administrator and a copy is to be retained by the Pastoral Designee.

Team Name: _____ Team City: _____

This release is to certify that _____ has been examined
(Student-athlete's name)
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**

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