Concussion/ Head Injury Permission to Return to Play

This form must be completed by a Licensed Healthcare Provider in order for a student-athlete to return to play after a suspected concussion/ head injury.

Student-Athlete Name: _____

Date of Injury:_____ Date of Evaluation:_____

Participation in Athletics: ☐ **Cleared** ☐ **NOT Cleared**

Please list any restrictions/accommodations that must be followed for the athlete to return to play:

_____

_____

_____

Additional comments or concerns:

_____

_____

Signature of Healthcare Provider: _____ Date: _____

Printed Name of Evaluating Healthcare Provider: _____

Contact Information of Healthcare Provider: _____

_____

Parents:

I, _____, give my permission for _____ to
(printed name of Parent/Guardian) (Name of student-athlete)
return to participation in athletics after a suspected concussion/ head injury.

Parent/ Guardian Signature: _____ Date: _____