ATHLETIC & ACTIVITIES DEPARTMENT

RETURN TO PLAY FORM

Student: ______________________________ School: ____________________________
Home Address: ____
Student Phone #: _______________________________________ (cell, home, or business)

INJURY/ILLNESS INFORMATION

Date of Injury: ___________________________ Location: ____________________
Sport: ___________________________________ Position: ____________________
Medical Treatment or Procedure: ____
____

RECOMMENDATIONS	DATE	TIME
No Restrictions as of	__________________	__________________
No Practice or play until	__________________	__________________
Light Running only – no contact	__________________	__________________
Regular practice - no contact	__________________	__________________

CONCUSSION PROTOCOLS (Required for all Head Concussions)

NOTE: Each step below must be 24 hours apart

	DATE	TIME
1. Cleared for Stress Test	__________________	__________________
2. Cleared for Sport Specific Conditioning	__________________	__________________
3. Cleared for Light Practice	__________________	__________________
4. Cleared for Full Practice	__________________	__________________
5. Cleared for Full Competition	__________________	__________________

Additional Comments: ____
____

____________________________________ Date: __________ Phone#: ___________
(Certified Athletic Trainer's Signature)

OR

____________________________________ Date: __________ Phone#: ___________
(Physician's Signature)