Return to Play Clearance Form

Youth Sports Concussion PROGRAM

Patient Name: _____ Date of Visit: _____

School: _____ Date of Birth: _____

❑ This Athlete **did not** sustain a concussion and may return to full activity.

This Athlete was diagnosed with a concussion and is permitted to return to full contact sports activities as of:

❑ Today

❑ _____

❑ Upon completion of the Youth Sports Concussion Program Return to Play Protocol

_____ _____

Name of Health Care Provider *Signature*

_____

Date