

MEDICAL RELEASE FOR RETURN TO ATHLETIC PARTICIPATION FOLLOWING A HEAD, NECK, CERVICAL COLUMN EXAMINATION

Student's Name: _____ Date of Examination: _____

Student's School: _____ Time of Examination: _____

This release is to certify that the above-named student has been examined due to experiencing the signs, symptoms, and behaviors consistent with a concussion or other brain injury, a neck injury, or a cervical column injury. Upon examination, it is my medical opinion that the above-named student:

_____ Is UNABLE to return to any participation in athletics until further notice.

_____ May RETURN TO FULL participation in athletics

Licensed Health Care Provider's Name Date

Licensed Health Care Provider's Signature Phone Number

MEDICAL RELEASE FOR RETURN TO ATHLETIC PARTICIPATION FOLLOWING A HEAD, NECK, CERVICAL COLUMN EXAMINATION

Student's Name: _____ Date of Examination: _____

Student's School: _____ Time of Examination: _____

This release is to certify that the above-named student has been examined due to experiencing the signs, symptoms, and behaviors consistent with a concussion or other brain injury, a neck injury, or a cervical column injury. Upon examination, it is my medical opinion that the above-named student:

_____ Is UNABLE to return to any participation in athletics until further notice.

_____ May RETURN TO FULL participation in athletics

Licensed Health Care Provider's Name Date

Licensed Health Care Provider's Signature Phone Number