



IOWA HIGH SCHOOL ATHLETIC ASSOCIATION

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: _____

- "Licensed health care provider" means a Medical Doctor, Doctor of Osteopathic Medicine, Doctor of Chiropractic, Physician's Assistant, Advanced Registered Nurse Practitioner, Physical Therapist, or certified Athletic Trainer. For wrestling meets, the "Designated, on-site, medical professional" needs to hold one of the aforementioned titles.

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 immediately

Licensed Health Care Provider's Name

Date

Licensed Health Care Provider's Signature

Phone Number

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