# RETURN TO ATHLETIC PARTICIPATION

Participant Name_____

Date of Medical Evaluation_____

Return to play release:

I authorize and clear the above-named participant to return to play and participate in Athletic practice and competition without restrictions on_____, 20____.

Additional notes:_____

_____

_____

Signature of Medical Provider*:_____

Printed Name of Medical Provider:_____

Office Address:_____

_____

Office Telephone Number: (_____)_____

*Clearance may only be given by a Medical Doctor (MD), Doctor of Osteopathy (DO), Advanced Registered Nurse Practitioner (ARNP), Physician's Assistant (PA), or a Naturopathic Physician (ND). If the athlete was evaluated for a head injury and possible concussion, you certify that you are trained in the evaluation and management of concussion.

PLEASE EMAIL THIS FORM BACK TO CCPSAFRONTDESK@OUTLOOK.COM

***NO FORMS WILL BE ACCEPTED IN PERSON***