CONCUSSION/ HEAD INJURY- RETURN TO PLAY FORM

Student Athlete's Name (Please Print): _____

Name of medical doctor or osteopathic
physician licensed under Title 26: _____

I personally examined the above student athlete for symptoms of concussion or other head injury on

_____ (date) and have released him/her to full participation in _____

(sport).

Certified by: _____
(Physician Signature) (Date)