Middle School Post-Concussion

Return to Practice or Play

Release Form

The following information must be completed by the licensed health care provider and returned to the middle school principal prior to returning to practice or play:

Student Name:	DOB:	Date of Incident:
School Name:	Grade:	
Parent(s) Name:	Phone:	Address:

❑ **Student did not suffer a concussion.**

❑ **Student suffered a concussion. Student has recovered and is cleared to fully return to practice or play.**

Additional Comments: _____

_____

_____

Licensed Health Care Provider Signature: _____ **Date:** _____

Facility Name: _____ **Facility/Contact Number:** _____

Parent Signature: _____ **Date:** _____

Date Received by School: _____

Copies provided to: School Clinic and Coach