CONCUSSION RETURN TO PLAY FORM:

MEDICAL CLEARANCE RELEASING THE STUDENT-ATHLETE TO RESUME FULL PARTICIPATION IN ATHLETICS

This form must be signed by one of the following examining Licensed Health Care Providers (LHCP) identified in the Gfeller-Waller Concussion Awareness Act before the student-athlete is allowed to resume full participation in athletics: Licensed Physician (MD/DO), Licensed Athletic Trainer (LAT), Licensed Physician Assistant (PA), Licensed Nurse Practitioner (NP), or Licensed Neuropsychologist. This form must be signed by the student-athlete's parent/legal custodian giving their consent before their child resumes full participation in athletics.

Name of Student-Athlete: _____ Sport: _____ Male/Female

DOB: _____ Date of Injury: _____ Date Concussion Diagnosed: _____

This is to certify that the above-named student-athlete has been evaluated and treated for a concussion and that the Return to Play Protocol was monitored by:

_____ at _____.

(Print Name of Person and Credential) (Print Name of School)

As the examining LHCP, I attest that the above-named student-athlete is now reporting to be completely free of all clinical signs and reports he/she is entirely symptom-free at rest and with both full cognitive and full exertional/physical stress and that the above-named student-athlete has successfully completed the required NCHSAA Concussion Return to Play Protocol through stage 5. By signing below therefore, I give the above-named student-athlete consent to resume full participation in athletics.

It is critical that the medical professional ultimately releasing this student-athlete to return to athletics after a concussion has appropriate expertise and training in concussion management. The NCHSAA, therefore, STRONGLY RECOMMENDS that in concussion cases, Licensed Athletic Trainers, Licensed Physician Assistants, Licensed Nurse Practitioners, consult with their supervising physician before signing this Return To Play Form, as per their respective state statutes.

_____ _____

Signature of Licensed Physician, Licensed Athletic Trainer, Licensed Physician Assistant, Licensed Nurse Practitioner, Licensed Neuropsychologist (Please Circle) Date

_____

Please Print Name

_____ _____

Please Print Office Address Phone Number

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Parent/Legal Custodian Consent for Their Child to Resume Full Participation in Athletics

I am aware that the NCHSAA **REQUIRES** the consent of a child's parent or legal custodian prior to them resuming full participation in athletics after having been evaluated and treated for a concussion. I acknowledge that the Licensed Health Care Provider above has overseen the treatment of my child's concussion and has given their consent for my child to resume full participation in athletics. By signing below, I hereby give my consent for my child to resume full participation in athletics.

_____ _____

Signature of Parent/Legal Custodian Date

_____

Please Print Name and Relationship to Student-Athlete

Rev: July 2021