RETURN TO ATHLETIC PARTICIPATION

Student Name: _____

Sport/Activity in Which Injury Occurred: _____

Date of the injury: _____

MEDICAL PROVIDER RELEASE FORM

Date of Medical Evaluation: _____

Return-To-Play Release:

I authorize and clear the above-named student 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: _____

_____

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 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 return this form to:

McMurray Middle School, 9329 SW Cemetery Road, Vashon, WA 98070.