

CONCUSSION MANAGEMENT

RETURN TO PLAY FORM

Reider Hockey LLC and its insurer requires that all participants comply with our Concussion Management Protocol and most state statutes require that an athlete be removed from any training, practice or game if they exhibit any signs, symptoms or behaviors consistent with a concussion or are suspected of sustaining a concussion. The player should not return to physical activity until he or she has been evaluated by a qualified medical provider who has provided written clearance to return to sports.

This form is to be used after an athlete has been removed from athletic activity due to a suspected concussion and must be signed by their medical provider in order to return without restriction to training, practice or competition.

Player Name: _____

Date of Birth: ____ / ____ / ____

District/Affiliate: _____

Name of Person Reporting: _____

Association and Team: _____

Date of Injury: ____ / ____ / ____

Location of Injury/Arena: _____

Injury Signs/Symptoms: _____

Print Health Care Professional Name: _____

License No: _____

Address: _____

Phone Number: _____

I HEREBY AUTHORIZE THE ABOVE NAMED ATHLETE TO RETURN TO ATHLETIC ACTIVITY FOR FULL PARTICIPATION WITHOUT RESTRICTION.

Signature: _____

Date: ____ / ____ / ____

I AM THE PARENT OR LEGAL GUARDIAN OF THE PLAYER IDENTIFIED ON THIS FORM AND I CONSENT TO THEIR RETURN TO ATHLETIC ACTIVITY WITHOUT RESTRICTION.

Parent/Legal Guardian Name: _____

Signature: _____

Date: ____ / ____ / ____

I AM THE COACH OF THE PLAYER IDENTIFIED AND I CONFIRM RECEIPT OF THIS CLEARANCE FORM ACKNOWLEDGING THE HEALTH CARE PROVIDER AND PARENT HAVE APPROVED THE ATHLETE'S RETURN TO PARTICIPATION WITHOUT RESTRICTION.

Coach Name: _____

Signature: _____

Date: ____ / ____ / ____