USA HOCKEY CONCUSSION MANAGEMENT
RETURN TO PLAY FORM

The USA Hockey 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 and competition.

Player Name: DOB: / /

Please cut here

Return this form to your District Player Safety Coordinator
(Information is used for data collection only. Name and DOB will not be shared)

District/Affiliate: _____ Name, email, phone # of person reporting: _____

Association & Team: _____ Date of injury: / / Age at time of injury: _____

Location of injury/Arena: _____

Injury signs/symptoms: _____

Age level of play: _____ (Y10U, Y14U, G10U, G12U, HS) Date of Initial Visit to Health Care Professional: / /

Print Health Care Professional Name: _____ License Number: _____

Role of Health Care Professional: (Physician, AT, Nurse Practitioner, etc.) _____

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.

Coaches Name: _____

Coach Signature: _____ Date: / /
