



## 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 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: \_\_\_\_\_

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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: \_\_\_\_/\_\_\_\_/\_\_\_\_

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**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: \_\_\_\_/\_\_\_\_/\_\_\_\_

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**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: \_\_\_\_/\_\_\_\_/\_\_\_\_