RETURN TO ATHLETIC PARTICIPATION

Participant Name_____

Date of Medical Evaluation_____

Return to play release:

I authorize and clear the above-named participant 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: _____

_____

Office 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 a 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.

YOU MAY FAX THIS FORM FROM THE DOCTORS OFFICE OR RETURN IT TO GREENWOOD COUNTY PARKS AND RECREATION.

Greenwood County Parks & Recreation FAX: 864.942.8609