

NJSIAA WRITTEN CLEARANCE/RETURN TO PLAY FORM

DATE OF COMPETITION/PRACTICE _____

NAME OF CONCUSSED/SUSPECTED CONCUSSED PLAYER _____

NUMBER OF CONCUSSED/SUSPECTED CONCUSSED PLAYER _____

TIME OF DAY/NIGHT INJURY OCCURRED _____

TIME OF DAY/NIGHT INJURED PLAYER RETURNED TO PLAY _____

TIME ON GAME CLOCK WHEN INJURED PLAYER WAS
REMOVED _____

TIME ON GAME CLOCK WHEN INJURED PLAYER RETURNED TO PLAY _____

PERIOD/QUARTER/HALF WHEN INJURED PLAYER WAS REMOVED _____

PERIOD/QUARTER/HALF WHEN INJURED PLAYER RETURNED TO PLAY _____

BRIEF DESCRIPTION OF SYMPTOMS NOTED AND SIDELINE EVALUATION

THIS RETURN-TO-PLAY IS BASED ON TODAY'S EVALUATION

On this ____ day of _____, 201__, I hereby authorize the above-named student to return to play and participate in today's competition without restrictions.

I hereby certify that I have received training in the evaluation and management of concussions. (N.J.S.A. 18A:40-41, 4)

SIGNATURE OF PHYSICIAN _____ M.D. D.O.
(Circle one)

PRINTED NAME OF PHYSICIAN _____

TITLE: _____

OFFICE ADDRESS OF PHYSICIAN: _____

TELEPHONE NO: _____

