Post Injury / Post Concussion Related Illnesses or Other Clearance for School Sports/Physical Education

Name of Student

Grade

May resume participation in school sports/physical education on

(DATE) __________________________

_______ with no limitations

_______ with the following limitations:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

May NOT resume participation in school sports/physical education

_______ until follow-up visit and clearance

from__________________________________________

(MD, PA, APRN-please print)

_______ Other (please specify: permanent excuse, completion of physical therapy, removal of cast, etc.)

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

MD, PA, APRN name (please print)__________________________________________

MD, PA, APRN signature__________________________________________ DATE_________

Address__________________________________________ Telephone______________________