Alamance County Recreation & Parks Concussion Return to Play Form

This form is to be used after a participant is removed from and not returned to program/play after exhibiting concussion signs or symptoms. The Alamance County Recreation & Parks Department requires written authorization from a physician approving the participant's return to Recreation & Parks Programs, with unrestricted activity, after exhibiting concussion signs or symptoms that resulted in the removal of a participant for the duration of program/play.

Participant's Name: ____________________

Date of Birth: ____________________

Date of Injury: ____________________

Reason for Participant's Incapacity: ____________________

THIS RETURN TO PLAY IS BASED ON TODAY'S EVALUATION

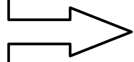
Date of Evaluation: ____________________

Name of Medical Doctor Completing Evaluation: ____________________

Return to Program/Play on (Date): ____________________

RETURN TO PLAY

PLEASE NOTE:



1. **Participants cannot return to play for a *minimum* of 24 hours after their head injury. An evaluation by a medical doctor with written consent is required to return.**
2. **Participants should never return to play if they still have ANY symptoms.**
3. **Participants: Be sure that your staff/athletic trainer are aware of your injury and symptoms.**

Medical Office Information:

I have examined ____________________ following this episode and determined they are cleared for full participation in all activities, without restrictions, on the date listed above for Alamance County Recreation & Parks Programs. I have explained to the parent/guardian that the return of signs symptoms should result in re-evaluation by a physician for re-assessment.

Physician Signature: ____________________ Date: __________

Print Physician Name: ____________________

Office Phone: ____________________

Office Address: ____________________

Recreation & Parks Office Use:

Date Received: ____________________ Received By: ____________________

Notes: ____________________

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