ATHLETIC & ACTIVITIES DEPARTMENT

KENT SCHOOL DISTRICT

RETURN TO PLAY FORM

Student: _____ School: _____
Home Address: _____
Student Phone #: _____ (cell, home, or business)
Diagnosed by: _____ Diagnosis Date: _____

INJURY/ILLNESS INFORMATION

Date of Injury: _____ Location: _____
Sport: _____ Position: _____
Medical Treatment or Procedure: _____
_____

RECOMMENDATIONS

	DATE	TIME
No Restrictions as of	_____	_____
No Practice or play until	_____	_____
Light Running only – no contact	_____	_____
Regular practice - no contact	_____	_____

CONCUSSION PROTOCOLS (Required for all Head Concussions)

NOTE: Each step below must be 24 hours apart

	DATE	TIME
1. Cleared for Stress Test	_____	_____
2. Cleared for Sport Specific Conditioning	_____	_____
3. Cleared for Light Practice	_____	_____
4. Cleared for Full Practice	_____	_____
5. Cleared for Full Competition	_____	_____

Meeting all the above required and necessary steps for releasing a youth athlete for unrestricted return to practice and competition does not encompass all aspects of medical decision making for this injury. The healthcare provider must additionally consider many modifiers and situations unique to the youth athlete in making the clearance decision. Additional Comments: _____
_____

Print: _____ Phone#: _____
Name of Licensed Healthcare Provider (MD, DO, ARNP, PA-C, LAT)
Signature: _____ Date: _____

This form is to be submitted to the School Athletic Administrator.
Date of Submission: _____ Signature: _____

Copies will be sent to the District Athletic Director and Director of Health Services.