Texas Association of Private and Parochial Schools

Concussion Return to Play Form

Student: _____ **Date of Birth:** _____

Gender: ☐ Female ☐ Male **Grade Level:** ☐ 9th ☐ 10th ☐ 11th ☐ 12th

School (City/School): _____

Date of Injury: _____ **Activity:** _____

Date of Initial Exam: _____

After consultation and examination, the above named student is released to return to activities as checked below. Restrictions to participation, if any, are as noted.

☐ **Student may return to practice on the following date:** _____

☐ **Student may return to full participation on the following date:** _____

☐ **Restrictions:**

_____

_____

_____

_____

Physician's Signature / Date

Physician's Name: _____

Office Address: _____

Office Phone: _____

By signature below, I agree that the above named student may return to participation as indicated above.

_____ _____

Parent / Guardian Signature **Date**