TEXAS ASSOCIATION OF PRIVATE AND PAROCHIAL SCHOOLS

Concussion - Return to Play Form

Student: _____ Date of Birth: _____

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

School-City: _____

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 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