RETURN TO PLAY PHYSICIAN FORM

The "Return to Play" form must be completed and signed by a licensed Medical Doctor (MD) or Doctor of Osteopathy (DO) per US Club Head Injury/Concussion Policy and returned to SAAZ and/or PCJSL.

PLAYER NAME: _____

DATE OF BIRTH: _____

DATE OF INJURY: _____

DATE OF EVALUATION: _____

SOCCER CLUB/TEAM (if available): _____

I have evaluated the athlete named above and my medical opinion is that:

☐ The athlete HAS NOT suffered a concussion and is medically returned to play on: _____/_____/_____

☐ The athlete HAS suffered a concussion and is NOT cleared to play and will be seen in a follow-up appointment on:

_____/_____/_____

☐ The athlete has demonstrated complete recovery from a concussion and may return to play on

_____/_____/_____ after he/she has completed a gradual return to play progression.

Physician Name (Print) _____

Physician Signature_____

Degree/Specialty _____

Date_____

SAAZ: Return form to Jonathan Berzins 1870 W 2nd Ave Durango, CO 81301

PCJSL: Return form to Pat Dunham, 6938 E. Hawthorne, Tucson, AZ 85710