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**