NJSIAA WRITTEN CLEARANCE/RETURN TO PLAY FORM

DATE OF COMPETITION/PRACTICE_____

NAME OF CONCUSSED/SUPSPECTED CONCUSSED PLAYER
_____
NUMBER OF CONCUSSED/SUSPECTED CONCUSSED PLAYER_____
TIME OF DAY/NIGHT INJURY OCCURRED_____
TIME OF DAY/NIGHT INJURED PLAYER RETURNED TO PLAY_____
TIME ON GAME CLOCK WHEN INJURED PLAYER WAS REMOVED_____
TIME ON GAME CLOCK WHEN INJURED PLAYER RETURNED TO PLAY

PERIOD/QUARTER/HALF WHEN INJURED PLAYER WAS REMOVED

PERIOD/QUARTER.HALF WHEN INJURED PLAYER RETURNED TO PLAY

BRIEF DESCRIPTION OF SYMPTOMS NOTED AND SIDELINE EVALUATION
_____
_____
_____

THIS RETURN-TO-PLAY IS BASED ON TODAY'S EVALUATION

On this _____ day of _____, 201__, I hereby authorize the above-named student to return to play and participate in today's competition without restrictions.

I hereby certify that I have received training in the evaluation and management of concussions. (N.J.S.A. 18A:40-41, 4)
SIGNATURE OF PHYSICIAN _____M.D. D.O.
(Circle one)
PRINTED NAME OF PHYSICIAN _____
TITLE: _____
OFFICE ADDRESS OF PHYSICIAN: _____
_____
TELEPHONE NO: _____