Return to Play Form

This form is to be used after an athlete is removed from the field of play after exhibiting concussion symptoms.

SAY Soccer rules require written authorization from a physician or other licensed medical professional before an athlete may return to play after exhibiting concussion symptoms that cause that athlete to be removed from the field. This athlete MAY NOT return to play nor participate in any SAY activity on the same day that he or she has been removed (even if a written medical clearance is provided).

Athlete name _______________________________ Date of injury ______________

Parent/Guardian __________________________________________________________

Area _____________________________ District ______________________________

Injury occurred during: (please circle one)

Practice  Game  Scrimmage  Tournament  Other

REASON FOR ATHLETE’S INCAPACITY

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

PHYSICIAN’S ACTION

I have examined the named athlete following the episode and determined the following:

☐ Permission is granted for the athlete to return to competition (may not return to practice or competition on the same day as the injury).

COMMENTS: _________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Physician’s Signature ________________________________ Date ______________

Physician’s Printed Name ____________________________________________________

Physician’s Primary Location of Practice ______________________________________

Physician’s Primary Office Phone # __________________________________________

Copies to: Team Coach, Area and/or District President (Duplicate as Needed)