



United Valley Soccer Association

938 Center Street, Hawthorn, PA 16230

P.O. Box 250, Hawthorn, PA 16230

www.unitedvalleysoccer.com



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's 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.

COMMENTS: _____

Physician's Signature _____ Date _____

Physician's Printed Name _____

Copies to: Team Coach, Area and/or District President

Duplicate as Needed