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 ___________________________

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

Duplicate as Needed