GLEN ROCK HIGH SCHOOL and MIDDLE SCHOOL

WRITTEN CLEARANCE/RETURN TO PLAY FORM FOR CONCUSSED ATHLETES

ATHLETE NAME _____ DOB (AGE): _____(___)
SCHOOL:_____ SPORT:_____

INJURY HISTORY

MECHANISM OF INJURY _____

_____

DATE OF INJURY_____ TIME OF ACTUAL INJURY _____
TIME REMOVED FROM PLAY: _____ TIME OF EVALUATION _____
WHO REMOVED ATHLETE FROM PLAY _____CREDS:_____
SIDELINE EVALUATION PERFORMED BY _____CREDS:_____
SYMPTOMS NOTED DURING SIDELINE EVALUATION

_____

_____

_____

NJSIAA CONCUSSION MANAGEMENT GUIDELNES

A student-athlete who participates in an interscholastic sports program and who sustains or is suspected of having sustained a concussion or other head injury while engaged in a sports competition or practice shall be immediately removed from activity. A student-athlete who is removed from competition or practice shall not participate in further sports activity until he/she is evaluated by a physician who is trained in the evaluation and management of concussions, **and receives written clearance from a physician trained in the evaluation and management of concussions to return activity.**

PHYSICIAN' S EVALUATION FINDINGS

DATE OF EVALUATION _____ TIME OF EVALUATION _____

CT SCAN (Circle One): NOT NEEDED NEGATIVE POSITIVE

DIAGNOSIS OF CONCUSSION (Initial One):
_____ABSENT: On this day, the_____ of _____, 20____, I hereby authorize the above-named student to return to play and participate in competition without restrictions.

_____PRESENT: The above-named student has sustained a concussion and should not return to participation in athletics until all NJSIAA and School District Return-To-Play criteria have been met.

By signing below, I hereby certify that I have received training in the evaluation and management of concussions. (N.J.S.A. 18A:40-41, 4)

PHYSICIAN SIGNATURE _____ M.D. D.O. (Circle one)
PHYSICIAN PRINTED NAME _____ DATE _____

OFFICE ADDRESS OF PHYSICIAN: _____

_____

_____

TELEPHONE _____