ILLNESS RETURN TO PLAY FORM:

Medical Clearance Releasing the Student-Athlete to Resume Full Participation in Athletics After an Illness

Before the student-athlete will be allowed to resume full participation in athletics, this form must be signed by one of the following Licensed Health Care Providers: Licensed Physician (MD/DO), Licensed Physician Assistant (PA), Licensed Nurse Practitioner (NP) and the student-athlete's parent/legal custodian.

Name of Student-Athlete: _____ DOB: _____

Diagnosis: _____

Date of Diagnosis: _____ Date Symptoms Resolved: _____

I release the above-named student-athlete to resume full participation in athletics.

_____ _____

Signature of Licensed Physician, Licensed PA, Licensed NP (Please Circle) Date

_____

Please Print Name

_____ _____

Office Address Office Phone Number

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Parent/Legal Custodian Consent

- I am aware that the North Carolina High School Athletic Association **REQUIRES** that student-athletes absent from athletic practice for five (5) or more days due to illness receive a medical release by either a physician licensed to practice medicine or his/her designee (licensed nurse practitioner, or licensed physician assistant) before readmittance to practice or contests.
- I acknowledge that the Licensed Health Care Provider listed above has provided medical care to my student-athlete.
- I acknowledge that the Licensed Health Care Provider listed above has released my student-athlete to resume full participation in athletics.

By signing below, I hereby give my consent for my child to resume full participation in athletics.

_____ _____

Signature of Parent/Legal Custodian Date

_____

Please Print Name and Relationship to Student-Athlete