



INJURY RETURN TO PLAY FORM:
**Medical Clearance Releasing the Student-Athlete to Resume
Full Participation in Athletics After an Injury**



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), Licensed Athletic Trainer (LAT) 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, Licensed AT (Please Circle) Date

Please Print Name

Office Address Office Phone Number

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 injury receive a medical release by either a physician licensed to practice medicine or his/her designee (licensed nurse practitioner, licensed physician's assistant, or licensed athletic trainer) 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