

Medical Release

Patient Name _____ Date of Evaluation _____

This athlete named above is cleared for a complete return to full contact sport participation as of _____ . The athlete is instructed to stop playing immediately and notify the coach, athletic director, trainer or team medical professional should his/her symptoms return.

Signature _____ Date _____

Name _____ (Print or Type Name Above) With _____ (Organization/School/Clinic/Club)

Phone: _____

Fax: _____

Email: _____