Morris School District

Morristown High School

Health Services

Date___________________

Concussion Release/Clearance for Student-Athletes

Student-Athlete's Name____

School____

TO BE COMPLETED BY THE STUDENT-ATHLETE'S HEALTH CARE PROVIDER

Student-Athlete MUST return the completed form to the Athletic Trainer

I certify that I have been trained in the evaluation and management of concussion to determine the presence or absence of a sports-related concussion or head injury.

I have examined the above-named student-athlete. My medical examination has determined the following: (Please check the appropriate box.)

☐ **This injury is NOT a concussion or other head injury. The student-athlete is asymptomatic at rest. Therefore, he/she may return to the interscholastic athletic activity.**

☐ **This injury is a concussion or other head injury. The student is symptomatic at rest. Therefore, he/she may NOT begin the graduated return to competition and practice protocol.**

☐ **This injury is a concussion or other head injury. The student is asymptomatic at rest. Therefore, he/she can begin the graduated return to competition and practice protocol.**

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Health Care Provider's Signature

____

Date Health Care Provider's Stamp

TO BE SIGNED BY THE SCHOOL OR TEAM PHYSICIAN IF #3 ABOVE IS CHECKED

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School or Team Physician's Signature