Florida High School Athletic Association

Revised 06/15

Post Head Injury/Concussion Initial Return to Participation

This form is to be completed by an appropriate health care provider (AHCP) trained in the latest concussion evaluation and management protocols as defined in FHSAA policy 40.2 for any student-athlete that has sustained a concussion and must be kept on file at the student-athlete's school. The choice of AHCP remains the decision of the parent/guardian or responsible party of the student-athlete. Completion of this form in itself does not guarantee playing time for the athlete.

Return to Competition Affidavit

Student-Athlete's Name: _____

Date of Birth: _____/_____/_____ Injury Date: _____/_____/_____

Formal Diagnosis: _____

School: _____

Sport: _____

I certify that I have reviewed the signed graded return to activity protocol provided to me on behalf of the athlete named above. This athlete is cleared for a complete return to **full-contact physical activity** as of _____/_____/_____.

This student-athlete is instructed to stop play immediately and notify a parent, licensed athletic trainer or coach and to refrain from activity should his/her symptoms return.

Physician Name: _____

Physician Signature:_____ License No.: _____

Phone: (_____) _____ Fax: (_____) _____ E-mail: _____

Date: _____/_____/_____