



Syracuse Parks & Recreation Concussion Return to Play Form

The purpose of this form is to be used after a participant is removed from and not returned to program/play after exhibiting concussion signs or symptoms. The Syracuse Department of Parks & Recreation requires written authorization, from a physician, approving the participant's return to Parks & Recreation Programs, with unrestricted activity, after exhibiting concussion signs or symptoms that resulted in the removal of a participant for the duration of program/play.

Participant's Name: _____

Date of Birth: _____

Date of Injury: _____

Reason for Participant's Incapacity: _____

THIS RETURN TO PLAY IS BASED ON TODAY'S EVALUATION

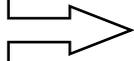
Date of Evaluation: _____

Name of Medical Doctor Completing Evaluation: _____

Return to Program/Play on (Date): _____

RETURN TO PLAY

PLEASE NOTE:



1. Participants cannot return to play for a minimum of 24 hours after their head injury. An evaluation by a medical doctor with written consent is required to return.
2. Participants should never return to play if they still have **ANY symptoms**.
3. Participants: Be sure that your staff/athletic trainer are aware of your injury and symptoms.

Medical Office Information:

I have examined _____ following this episode and determined they are cleared for full participation in all activities, without restrictions, on the date listed above for Syracuse Parks & Recreation Programs. I have explained to the parent/guardian that the return of signs symptoms should result in re-evaluation by a physician for re-assessment.

Physician Signature: _____ Date: _____

Print Physician Name: _____

Office Phone: _____

Office Address: _____

Parks & Recreation Office Use:

Date Received: _____ Received By: _____

Notes: _____
