Concussion Return To Competition Clearance Form

The below named athlete had medical guidance on-site at an event and suffered a concussion or demonstrated signs, symptoms or behaviors consistent with a concussion on the date of injury noted.

_____ _____

Athlete Name *Date Of Injury*

Concussion Status

☐ After reviewing the available medical facts, it is my opinion the above named rider did NOT sustain a concussion and is medically released to return to play in the sport of bicycle motocross.

☐ The above named athlete DID sustain a concussion and the rider has been instructed in the recognition of signs, symptoms, and the progression of a concussion. This individual should consult with the managing health care professional when necessary and shall consult (may be in person, by phone or e-mail) with a managing health care professional prior to the release.

☐ The above named athlete DID sustain a concussion and the rider has been instructed in the recognition of signs, symptoms, and the progression of a concussion. I am the managing health care professional or primary care physician for the above named athlete has progressed thru the recommended steps for return to play and is cleared to participate.

Education Status

☐ As a health care professional I have within 3 years of the date of evaluation completed a continuing education course in the evaluation and management of concussion.

☐ As a health care professional I have not completed a continuing education course in the evaluation and management of concussion within the 3 years of the date of evaluation.

By signing this form the health care professional is certifying they are a licensed health care provider practicing within their scope of practice. This signature invokes the condition checked above.

_____ _____

Health Care Professional Signature *Health Care Professional Name*

_____ _____

Date Of Evaluation *Office Phone*

_____

Health Care Professional Office Address