Worcester Public Schools

RETURN TO ATHLETIC PARTICIPATION FORM

TO BE COMPLETED BY A SCHOOL OFFICIAL **Record No.**_____

1. **Student's Name** _____ **School** _____

   Home Address _____ **Phone** _____

   Grade _____ **Age** _____ **Date of Birth** _____

2. **Injury (Illness) Information** _____

   _____

   Time/Date of Injury _____ ☐ **Game** ☐ **Practice**

   Type of Injury _____

   Sport _____ **Position Played** _____

   _____

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*TO BE COMPLETED BY MEDICAL PROVIDER (*a duly licensed physician; a certified athletic trainer in consultation with a licensed physician; a duly licensed nurse practitioner in consultation with a licensed physician; or a neuropsychologist after the student has been examined and cleared by a licensed physician.)

3. **Description of Injury** _____

   _____

4. **Referred** _____

   Recommendations/Restrictions _____

   a. **No restrictions. Discharged as of** _____
   (Date)

   I have examined _____ **and certify that he/she is recovered**

   _____

   incurred on _____.
   (Date)

   b. **No practice or competition until** _____.
   (Date)

   c. **Expected return to activity (after further evaluation)** _____.
   (Date)

   d. **No restrictions. Discharged as of** _____.
   (Date)

   e. **Required restrictions. (No contact, light practice only, etc.)** _____

   f. **Other** _____

Medical Provider's Signature	**Date**	**Parent's Signature**	**Date**
Coach's Signature	**Date**	**Student's Signature**	**Date**