MEDICAL CLEARANCE TO RETURN TO PLAY
LINCOLN ICE HOCKEY ASSOCIATION

This form must be signed by a licensed health care professional defined within the Nebraska Concussion Awareness Act (passed by the Nebraska Legislature in 2011) as "a physician or licensed practitioner under the direct supervision of a physician, e.g. PA-C or APRN; a neurophysiologist, an athletic trainer; or a qualified individual able to (a) provide health care services where doing so falls within one's scope of practice in Nebraska, AND (b) is trained in the evaluation and management of traumatic brain injury among a pediatric population.

Patient's Name _____

Sex: _____Age: _____ Date of Birth: _____

After being told the patient was "reasonably suspected" of having sustained a concussion, I have examined the patient and by my signature below, I clear the patient to return to youth hockey practices and games.

Name of Licensed Health Care Professional (printed) _____

Complete Address _____
_____

Phone (____) _____-_____ Fax (____) _____-_____

Date ____/____/_____

Signature of Licensed Health Care Professional _____

Parent/Legal Guardian Clearance Form

As the parent/legal guardian of _____, I give my permission for my son/daughter to return to youth hockey practice and games.

Name of parent/legal guardian (printed) _____

Signature of parent/legal guardian _____

Date ____/____/_____