

# USA HOCKEY CONCUSSION MANAGEMENT RETURN TO PLAY FORM

The USA Hockey Concussion Management Protocol and most state statutes require that an athlete be removed from any training, practice or game if they exhibit any signs, symptoms or behaviors consistent with a concussion or are suspected of sustaining a concussion. The player should not return to physical activity until he or she has been evaluated by a qualified medical provider who has provided written clearance to return to sports. **Every section of the form MUST be filled out completely!**

This form is to be used after an athlete has been removed from athletic activity due to a suspected concussion and must be signed by their medical provider in order to return **without restriction** to training, practice and competition.

**Return this form to the Midwest Player Safety Representative at [kburkelake@yahoo.com](mailto:kburkelake@yahoo.com)**  
*(Information is used for USA Hockey Internal data collection only. Name and DOB will not be shared)*

Player Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

District/Affiliate: Central/Midwest Name of person reporting: \_\_\_\_\_

Association & Team: \_\_\_\_\_ Date of injury: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Location of injury/Arena: \_\_\_\_\_  
City, State, Name of Ice Arena

Injury signs/symptoms: \_\_\_\_\_

Age Level of Play: \_\_\_\_\_ Date of Initial Visit to Health Care Professional: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Y12U, G10U, Y14U, etc.

Print Health Care Professional Name: \_\_\_\_\_ License Number: \_\_\_\_\_

Role of Health Care Professional: (Medical, Orthopedic, Pediatric, etc.) \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

***I HEREBY AUTHORIZE THE ABOVE-NAMED ATHLETE TO RETURN TO ATHLETIC ACTIVITY FOR FULL PARTICIPATION WITHOUT RESTRICTION.***

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

***I AM THE PARENT OR LEGAL GUARDIAN OF THE PLAYER IDENTIFIED ON THIS FORM AND I CONSENT TO THEIR RETURN TO ATHLETIC ACTIVITY WITHOUT RESTRICTION.***

Parent/Legal Guardian Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

***I AM THE COACH OF THE PLAYER IDENTIFIED AND I CONFIRM RECEIPT OF THIS CLEARANCE FORM ACKNOWLEDGING THE HEALTH CARE PROVIDER AND PARENT HAVE APPROVED THE ATHLETE'S RETURN TO PARTICIPATION WITHOUT RESTRICTION.***

Coaches Name: \_\_\_\_\_

Coach Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_