GATES METROS / GATES YOUTH SOCCER, INC.

Concussion Return to Play Form

This form is to be used after an athlete is removed from the field of play after exhibiting concussion symptoms.

NYSWYSA Soccer rules require written authorization from a physician or other licensed medical professional before an athlete may return to play after exhibiting concussion symptoms that cause that athlete to be removed from the field. This athlete MAY NOT return to play nor participate in any Gates Soccer activity on the same day that he or she has been removed (even if a written medical clearance is provided).

Athlete name _____ **Date of injury** _____

Parent/Guardian _____

Area _____ **District** _____

Injury occurred during: *(please circle one)*

Practice Game Scrimmage Tournament Other

REASON FOR ATHLETE'S INCAPACITY

_____

_____

_____

PHYSICIAN'S ACTION

I have examined the named athlete following the episode and determined the following:

☐ **Permission is granted** for the athlete to return to competition (may **not** return to practice or competition on the same day as the injury).

COMMENTS: _____

_____

Physician's Signature _____ **Date** _____

Physician's Printed Name _____

Physician's Primary Location of Practice _____

Physician's Primary Office Phone # _____

Copies to: Team Coach, Area and/or District President *(Duplicate as Needed)*