idgefield High School • Department of Athletics

RETURN TO PLAY FORM

Name of Injured Athlete:____________________________________Grade: ________Age: _______

Sport Participating In: ____________________________Position: ____________________________

DETAILS OF INJURY

Date of Injury: ____Time: ________________________

Injured During: Practice: _____________ Game: ____________ Other: ________________________

Mechanism of Injury: ____

TO BE COMPLETED BY PHYSICIAN

Impression/Diagnosis: ____

Recommendations:

No Restrictions (discharged) as of: ____

No Practice or Play until: ____

Expected Return to Activity (definite date upon further evaluation) _______________________

Other: ____

TREATMENT AVAILABLE AT RIDGEFIELD HIGH SCHOOL

treatment requires MD signature below

Please Check:

____ Cold packs/Ice
____ Hydrocollator Packs
____ ROM/Stretching

____ Strengthening/PRE's
____ Whirlpool/Contrast Bath
____ Stationary Bike

____ Electric Muscle Stim.
____ Referred for formal P.T./Treatment

Physician: ____ Date: __________________

Signature: ____

STUDENT ATHLETES WILL NOT BE ALLOWED TO RETURN TO SPORTS UNTIL THIS FORM OR SIMILAR FORM HAS BEEN SIGNED BY A PHYSICIAN AND RETURNED TO THE RIDGEFIELD HIGH SCHOOL ATHLETICS DEPARTMENT

Revised 08/2010