**BHS Athletic Injury Return-to-Play Form**

**On site evaluation by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name/position)** Date of incident: \_\_\_\_\_\_\_\_\_\_

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Graduation YEAR**: \_\_\_\_\_\_\_\_

Sport/Event: \_\_\_\_\_\_\_\_\_\_\_\_\_How did injury occur: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***This form needs to be taken to your doctor’s appointment, filled out, and returned to the Athletic Trainer or faxed to (425) 408-7002 before returning to sport participation.***

***OR***

***Medical evaluation note with information required on this return- to- play form must be given to the Athletic Trainer.***

**This form is not for concussion clearance; use the “Concussion Return-to-Play Protocol” form.**

Date of visit: \_\_\_\_\_\_\_\_\_\_ Reason for visit:

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**MEDICAL PERSONNEL TO COMPLETE  *appropriate section ( I – III below)***

**I.** Patient is allowed to return to full activity as of (date).

 Describe any special instructions, care or treatment (bracing, taping, icing protocol):

**II.** Patient is cleared for partial participation as of date).

 Partial activity includes:

Running Exercise Bike Swimming

Stretching Weight Lifting Sport Specific Drills

Light Aerobic Non-Contact Practice

Other:

**III.** Patient is **not cleared** to return to any activity as of (date).

 A follow up appointment is scheduled for:

Physician’s Signature: Date:

**Physician’s Name: please print**: Phone:

Athletic Trainer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(signature upon return) Date: \_\_\_\_\_\_\_\_\_\_

If there is other supporting documentation it is attached:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(trainer initial)