**Post Head Injury/Concussion Medical Clearance for Return to Participation – Storm Select Lacrosse**

This form is to be completed by an appropriate health care provider (AHCP-MD/DO) trained in the latest concussion evaluation and management protocols as defined in FL Statute 943.0438 for any youth player that has sustained a concussion and must be kept on file with the **Storm Select Lacrosse.** The choice of AHCP remains the decision of the parent/guardian or responsible party of the youth player.

Athlete Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

Location of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injury Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

**By signing below, I certify that I am a medical doctor (MD/DO) familiar with the most current Consensus Statement on Concussion in Sports and the tools used for evaluation (ex. SCAT5). This information will be used to guide return to play progression (page 1) and final clearance to return to competition.**

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature/Degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD/DO

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Return to Competition Affidavit

Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ Injury Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

Formal Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I have reviewed the return to activity protocol provided to me on behalf of the athlete named above. This youth player is cleared for a complete return to **full-contact physical activity** as of \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_.

**This youth player is instructed to stop play immediately and notify a parent, licensed athletic trainer or coach and to refrain from activity should his/her symptoms return.**

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MD/DO Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***By signing above, I certify that I am a medical doctor (MD/DO) familiar with the most current 2016 Consensus Statement on Concussion in Sport and the tools used for evaluation (ex: SCAT5). This information will be used to guide return to play progression (page 1) and final clearance to return to competition.***