

Florida High School Athletic Association  
**Post Head Injury/Concussion Initial Return to Participation** *(Page 2 of 2)*

This form must be completed for any student-athlete that has sustained a sports-related concussion and must be kept on file at the student-athlete's school.

**Return to Competition Affidavit**

Student-Athlete's Name: \_\_\_\_\_

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

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

School: \_\_\_\_\_

Sport: \_\_\_\_\_

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

This student-athlete 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: \_\_\_\_\_ License No.: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

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

