NEW JERSEY STATE INTERSCHOLASTIC ATHLETIC ASSOCIATION
1161 ROUTE 130 NORTH P.O. BOX 487 ROBBINSVILLE, NJ 08691-0487

NJSIAA WRITTEN CLEARANCE/RETURN TO PLAY FORM

Date of competition/practice: _____

Name of suspected concussed player:_____

Jersey number of suspected concussed player:_____

Time of day/night injury occurred:_____

Time of day/night injured player returned to play:_____

Time on game clock when injured player returned to play:_____

Period/quarter/half when injured player was removed_____

Period/quarter/half when injured player returned to play_____

Brief description of symptoms noted and sideline evaluation_____

_____

This return-to-play is based on today's evaluation on this _____ day of _____,

201_____, I hereby authorize the above-named student to return to play and participate in today's competition without restrictions.

I hereby certify that I have received training in the evaluation and management of concussions. (N.J.S.A. 18a:40-41, 4)

Signature of physician _____MD, DO
(circle one)

Printed name of physician: _____

Title: _____

Office address of physician: _____

Telephone No:_____