# Worcester Public Schools

# RETURN TO ATHLETIC PARTICIPATION FORM

*TO BE COMPLETED BY A SCHOOL OFFICIAL* **Record No.**_____

1. **Student's Name** _____ **School** _____

   **Home Address** _____ **Phone** _____

   **Grade** _____ **Age** _____ **Date of Birth** _____

2. **Injury (Illness) Information** _____

   _____

   **Time/Date of Injury** _____ ☐ **Game** ☐ **Practice**

   **Type of Injury** _____

   **Sport** _____ **Position Played** _____

   _____

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*TO BE COMPLETED BY MEDICAL PROVIDER (*a duly licensed physician; a certified athletic trainer in consultation with a licensed physician; a duly licensed nurse practitioner in consultation with a licensed physician; or a neuropsychologist after the student has been examined and cleared by a licensed physician.)

3. **Description of Injury** _____

   _____

4. **Referred** _____

   **Recommendations/Restrictions** _____

   a. **No restrictions. Discharged as of** _____
   (Date)

   **I have examined** _____ **and certify that he/she is recovered**

   _____

   **incurred on** _____.
   (Date)

   b. **No practice or competition until** _____.
   (Date)

   c. **Expected return to activity (after further evaluation)** _____.
   (Date)

   d. **No restrictions. Discharged as of** _____.
   (Date)

   e. **Required restrictions. (No contact, light practice only, etc.)** _____

   f. **Other** _____

| | | | |
|---|---|---|---|
| **Medical Provider's Signature** | **Date** | **Parent's Signature** | **Date** |
| **Coach's Signature** | **Date** | **Student's Signature** | **Date** |