ASA CONCUSSION RETURN TO PLAY - PHYSICIAN FORM

Return completed form to ASA – medical@azyouthsoccer.org	
STUDENT NAME:	
DATE OF BIRTH:	
DATE OF INJURY:	
DATE OF EVALUATION:	
SOCCER CLUB/TEAM:	

I have evaluated the athlete named above and my medical opinion is that:

_____The athlete **HAS NOT** suffered a concussion and is medically returned to play on:_____/_____/_____

_____The athlete **HAS** suffered a concussion and is **NOT** cleared to play and will be seen in a follow-up appointment on: _____/_____/_____

_____The athlete has demonstrated complete recovery from a concussion and may return to play on _____/_____/_____ due to the fact that they have completed a gradual return to play progression and a neurological exam & neurocognitive testing.**

(***Neurocognitive testing is not mandatory at this time, but is strongly encouraged by ASA to indicate a complete recovery. Especially in cases where a baseline test has been completed.)*

The ASA "Return to Play" form must be completed and signed by a licensed Medical Doctor (MD) or Doctor of Osteopathy (DO) per ASA Head Injury/Concussion Policy

At this time, the student is:

☐ Symptom-free at rest

☐ **NOT** symptom-free at rest

☐ Symptom-free with exertion

☐ **NOT** symptom-free with exertion

_____ _____ _____ _____/_____/_____

Physician Name (Print) Physician Signature Degree/Specialty Date

_____ _____

Physician Office Phone Number Physician Office Fax Number