Parsippany Hills High School
Concussion Clearance Form

To be completed by treating physician

Name of Athlete/Patient _____

Date of Injury _____

Please check one of the following:

☐ Athlete did not sustain a concussion and can return to practices on _____.

☐ Athlete is still symptomatic.

☐ Athlete is asymptomatic. The Graduated Return To Competition and Practice Protocol (printed on the back of this form) can begin on _____.

Follow-Up Visit Recommended? Yes No

If yes, when? _____.

If ImPACT test results were not available, do you want them faxed to you? Yes No

Fax Number _____.

Do you want a post-injury ImPACT test taken? Yes No

Do you want to be contacted regarding progress prior to beginning contact practices? Yes No

Phone number to contact you _____.

☐ **I affirm I am a physician trained in the treatment and management of concussive injuries.**

Signature: _____ **Date:** _____

Print Name or Stamp: _____ **Phone Number:** _____