Mercer Island High School
Athletic Injury Return-to-Play Form

Please take this form to your doctor’s appointment to be filled out. This form must be completed and returned to the Athletic Trainer or faxed to (206) 230-6316 before returning to sport participation. This form is not for concussion clearance; see the “Concussion Return-to-Play Protocol” form.

Patient’s Name:__________________________________________________________

Reason for visit:________________________________________________________________

Date of visit:____________________ Date of Injury:__________________________

Check option and fill in information

I. _____ Patient is fully cleared to return to ___________________ (sport) as of ______(date).

Any special care or treatment (bracing, taping, icing protocol): __________________________

____________________________________________________

____________________________________________________

II. _____ Patient is able to return to partial activity for____________________ (sport) as of ______(date).

Partial activity includes:

_____ Running _____ Exercise Bike _____ Swimming

_____ Stretching _____ Weight Lifting _____ Sport Specific Drills

_____ Light Aerobic _____ Non-Contact Practice

_____ Other: _____________________________

III. _____ Patient is not cleared to return to any activity as of _____________(date).

A follow up appointment is scheduled for: ________________________________

Place office stamp or attach business card here:

____________________________________________________

Physician’s Signature:___________________________ Date:____________________

Physician’s Name: ________________________________ Phone: _____________________