

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: _____