RETURN TO PLAY FORM:

Medical Clearance Releasing the Student-Athlete to Resume Full Participation in Athletics After an Illness or Injury

Before the student-athlete will be allowed to resume full participation in athletics, this form must be signed by one of the following Licensed Health Care Providers: Licensed Physician (MD/DO), Licensed Physician Assistant (PA), Licensed Nurse Practitioner (NP) and the student-athlete's parent/legal custodian.

Name of Student-Athlete: _____DOB: _____

Diagnosis: _____

Date of Diagnosis : _____ Date Symptoms Resolved: _____

I release the above-named student-athlete to resume full participation in athletics.

_____MD DO PA NP _____

Signature of Licensed Physician, Licensed Physician Assistant, Licensed Nurse Practitioner (Please Circle) — Date

_____

Please Print Name

Physician Office Stamp:	Address_____ _____ Phone:_____

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Parent/ Legal Custodian Consent

- I am aware that the North Carolina High School Athletic Association/WCPSS **REQUIRES** that student-athletes absent from athletic practice for five (5) or more days due to illness or injury shall receive a medical release by either a physician licensed to practice medicine or his/her designee (nurse practitioner, or physician's assistant) before readmittance to practice or contests..
- I acknowledge that the Licensed Health Care Provider listed above has provided medical care to my student-athlete.
- I acknowledge that the Licensed Health Care Provider listed above has released my student-athlete to resume full participation in athletics.

By signing below, I hereby give my consent for my child to resume full participation in athletics.

_____ _____

Signature of Parent/ Legal Custodian — Date

_____

Please Print Name and Relationship to Student-Athlete