

MEDICAL RELEASE FOR RETURN TO ATHLETIC PARTICIPATION

This release is to certify that _____ has been examined
(Student athlete's name)

due to exhibiting the signs or symptoms consistent with sudden cardiac arrest. Following an examination, it is my medical opinion that he/she

___ **Is unable to return to participation in athletics until further notice**

Return appointment scheduled on: _____
(Date)

___ **May return to limited participation in athletics on** _____
(Date)

___ **Following return to limited participation this student needs to return for re-evaluation before being released for full participation in athletics.**

___ **May return to full participation in athletics on** _____
(Date)

Restrictions: _____

Health Care Provider's Name (Type or Print)

Date

Health Care Provider's Signature

Date