WHSAA RETURN TO PLAY FORM

Office:

Date: _____

This is to certify that _____ has been under my care for the following:

_____

_____

And is able to return to athletic practices/participation on _____ under the following conditions:
Day Month

Unrestricted:
Restricted/Limited to: _____

_____

Comments (Recommended Rehab plan for return to play)

_____

Physicians Name (Please print clearly) _____

Physicians Signature _____ Phone _____

I agree with above plan and am knowledgeable about my child's condition and situation

Parent Signature _____ Date _____

1 Copy Each
School
Parent
Dr. Office

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