MEDICAL CLEARANCE FORM
FOR RETURN TO PLAY

UNIVERSITY OF TORONTO SCARBOROUGH

CLIENT INFORMATION

Student Name: _____ Student #: _____

Student Signature: _____ Date : _____/_____/_____
DD MM YYYY

The time needed to return to play will vary with the severity of the concussion and with the player. Please have your physician complete this form and submit to your coach if you wish to return to your sport or activity.

TO BE COMPLETED BY PHYSICIAN

Please initial the level of activity the client is permitted to return to. The client is advised to only engage in activities as tolerated and consult a physician if concussion symptoms persist.

Initial(s)	Level of Activity	Description
	Light aerobic exercise	Activities such as walking or stationary cycling. The player should be supervised by someone who can help monitor for recurring symptoms of concussion. No resistance training or weight lifting. The duration and intensity of the aerobic exercise can be gradually increased over time as long as no symptoms of concussion return during the exercise or the next day.
	Sport-specific activities	Activities such as skating or throwing can begin. There should be no body contact or other jarring motions such as high speed stops or hitting a baseball with a bat.
	Drills without body contact	Activities such as team drills and exercises during practices as tolerated. No activities that may include body contact such as scrimmages or drills.
	On-field practice with body contact	Activities such as team drills, exercises and scrimmages as tolerated.
	Game play	Client is cleared to return to full sporting activity.

PHYSICIAN'S STAMP HERE

CPSO#:

Physician's Signature: _____

Date : _____/_____/_____
DD MM YYYY