CMP CONCUSSION MANAGEMENT PARTNERS INC. Student-Athlete Concussion Management Program

MEDICAL CLEARANCE TO RESUME GRADUAL PHYSICAL TRAINING FOR RETURN TO SPORTS COMPETITION

NAME OF STUDENT-ATHLETE	
ADDRESS:	
PHONE:	
NAME OF SCHOOL/TEAM	
SPORT/ACTIVITY	
DETAILS OF INJURY	DATE OF INJURY:
The above-named student-athlete was examined and/or treated for symptoms of a possible concussion.	
I certify that, as of this date, the above named student-athlete does not exhibit any medical reason which would prevent the beginning of a gradual physical training process for the purpose of returning to sports participation.	
NOTES / DIRECTIONS FROM EXAMINING PHYSICIAN	
SIGNATURE OF EXAMINING PHYSICIAN	
NAME OF EXAMINING PHYSICIAN:	
TODAY'S DATE:	