TULANE CAMPUS RECREATION
Division of Student Affairs

COMPETITIVE SPORTS RETURN-TO-PLAY CLEARANCE FORM

_____suffered a suspected head injury on _____ while participating in _____sport or activity.

Note to Athlete: In order to return to play, you must be evaluated by a health care professional and submit this completed form to the Campus Recreation Office in Reily Center, Suite 105. Make an appointment for evaluation with the Primary Care Unit at the Tulane Student Health Center within 24-72 hours of injury by calling **(504) 865-5255**.

If you experience any of the following symptoms go to the ER as soon as possible:

□ Loss of consciousness □ Severe nausea and vomiting □ Seizure □Altered mental status

Important things to tell your physician:

- Cause of the injury and force of the hit or blow to the head or body
- Any loss of consciousness and if so, for how long
- Any memory loss or seizures immediately following the injury
- Number of previous concussions (if any)

Physician's/Provider's Use Only:

_____Cleared to return to play without restriction.

_____Cleared to return to play with restrictions (please list).

_____Cleared to return to play on _____.

_____Return appointment with provider required by _____.

_____Referred to local provider for further care. Cannot return to play at this time.

My signature indicates I understand the student's condition and the sport in which the student will be participating and my findings are based on my medical assessment of this student's physical capabilities.

_____ _____
Provider's Name (printed) Provider's Signature

_____ _____
Name of Practice Date

I AGREE THAT I WILL FOLLOW THROUGH WITH ALL THE RESTRICTIONS LISTED ABOVE. I FURTHER AGREE THAT I WILL NOTIFY THE ASSISTANT DIRECTOR OF CAMPUS RECREATION OF ANY DEVIATION FROM THESE RESTRICTIONS.

Student's Signature_____Date_____

Campus Recreation Office Use Only:

Received By:_____ Date Stamp:_____

Approved By:_____ Date Stamp:_____