NEW JERSEY STATE INTERSCHOLASTIC ATHLETIC ASSOCIATION
1161 ROUTE 130 NORTH P.O. BOX 487 ROBBINSVILLE, NJ 08691-0487
NJSIAA WRITTEN CLEARANCE/RETURN TO PLAY FORM

Date of competition/practice: ________________________________

Name of suspected concussed player: __________________________

Jersey number of suspected concussed player: __________________

Time of day/night injury occurred: ________________________________

Time of day/night injured player returned to play: __________________

Time on game clock when injured player returned to play: ________________

Period/quarter/half when injured player was removed ________________

Period/quarter/half when injured player returned to play ________________

Brief description of symptoms noted and sideline evaluation ________________

____________________________________________________________________

This return-to-play is based on today’s evaluation on this _____ day of ____________,
201____, I hereby authorize the above-named student to return to play and participate in
today’s competition without restrictions.

I hereby certify that I have received training in the evaluation and management of
concussions. (N.J.S.A. 18a:40-41, 4)
Signature of physician ____________________________________________

(circle one)

Printed name of physician: _________________________________________

Title: ___________________________________________________________

Office address of physician: ________________________________________

Telephone No:____________________________________________________