Mount Greylock Regional High School

Athletic Department
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Williamstown, MA 01267

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RETURN TO ATHLETIC PARTICIPATION

STUDENT'S NAME	SCHOOL Mount Greylock Regional High School	
HOME ADDRESS	TEL	
GRADE	AGE	
Injury (illness) information		
Time and date of injury	Contest or practice	
Type of injury	Sport	Position played
Coach		Tel

TO BE COMPLETED BY PHYSICIAN

1. Description of injury _____

   _____

2. Referred _____

   Recommendations/restrictions _____

   a. No restrictions (discharged) as of _____ (DATE)

      I have examined _____ (STUDENT) and certify that he/she is

      recovered from _____

      incurred on _____ (DATE)

   b. No practice or competition until _____ (DATE)

   c. Expected return to activity (after further evaluation) _____ (DATE)

   d. Please state restrictions which you require (e.g. no contact, light practice only, etc.) _____

   e. Other _____

PHYSICIAN'S SIGNATURE _____ DATE _____

PARENT'S SIGNATURE _____ DATE _____

COACH'S SIGNATURE _____ DATE _____

STUDENT'S SIGNATURE _____ DATE _____