



## Player Return to Play Form – Upcoming Game

The Westchester Youth Soccer League (WYSL) has developed this form as a uniform method for a Health Care Professional (HCP), as defined below, to medically clear a player to return to play in future games after having been removed from a WYSL game due to a determination that the player showed signs or reported symptoms consistent with having suffered a concussion or other traumatic brain injury or where the player actually suffered such an injury, during a WYSL game or otherwise.

This form should be completed and signed by a “Health Care Professional” (or HCP) who, as defined in the US Soccer Recognize 2 Recover Concussion Initiative Guidelines (US Soccer Guidelines), is a licensed professional, such as an athletic trainer certified (ATC) or physician (MD/DO), with skills in emergency care, sports medicine injuries and experience related to concussion evaluation and management, only under circumstances where the HCP believes that the player is free of symptoms and ready to return to unrestricted athletic activities, including competitive soccer games.

A player who been removed from a WYSL game due to a determination that the player showed signs or reported symptoms consistent with having suffered a concussion or other traumatic brain injury MAY NOT return to play in a subsequent WYSL game or other WYSL-sanctioned competition or event unless and until THIS FORM is completed and signed by an HCP and delivered to the WYSL office in advance of the upcoming competition/event.

Player Name: \_\_\_\_\_

Club Name: \_\_\_\_\_

Team Name: \_\_\_\_\_

Date of Game\*: \_\_\_\_\_

Time of Game\*: \_\_\_\_\_

Date of Assessment: \_\_\_\_\_

Time of Assessment: \_\_\_\_\_

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\*Not required when player is not removed from a WYSL game due to suspicion of a concussion or traumatic brain injury.

EVALUATION AND DIAGNOSIS

The above-named player has been found to HAVE NOT suffered a concussion or other traumatic brain injury OR, if such player had suffered such an injury, he/she is now free of symptoms and is medically cleared to return to unrestricted athletic activities, including competitive soccer games, in accordance with an appropriate graduated Return to Play (RTP) protocol.

Health Care Professional (print): \_\_\_\_\_

Health Care Professional (signature): \_\_\_\_\_

Qualification: (MD, DO, ATC, etc.) \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

QUALIFIED HEALTH CARE PROVIDER STATEMENT

I, \_\_\_\_\_, am a Health Care Professional as specified in the US Soccer Guidelines. I am a licensed professional, such as an athletic trainer certified (ATC) or physician (MD/DO), as specified above, with skills in emergency care, sports medicine injuries and experience related to concussion evaluation and management. I am trained in the management, evaluation, and treatment of a concussion and can evaluate and manage a concussion within the scope of my practice.

Signature: \_\_\_\_\_

Date and Time: \_\_\_\_\_