WYSL
WESTCHESTER YOUTH SOCCER LEAGUE

Player Return to Play Form – Same 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 present a written release for a player to return to play in the same game 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.

This form is specific to the situation where a player has been removed from a WYSL game due to such a determination and there is an HCP onsite who, complying with the US Soccer Recognize 2 Recover Concussion Initiative Guidelines (US Soccer Guidelines), determines that the player in question did not suffer a concussion or other traumatic brain injury and desires to clear that player to resume play in the same game. For purposes of this form, a "Health Care Professional" (or HCP) is, as defined in the US Soccer Guidelines, 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.

A player MAY NOT return to play in the same game unless and until THIS FORM is completed and signed by an onsite HCP and handed to the referee(s) officiating that game. Such referee(s) shall nevertheless have the discretion to keep the player from returning to the game. If the referee(s) do(es) allow the player to return to the game, the referee(s) will do so in full reliance on the statements and assessment made by the HCP herein.

Player Name: _____

Club Name: _____

Team Name: _____

Date of Game: _____

Time of Game: _____

Date of Assessment: _____

Time of Assessment: _____

EVALUATION AND DIAGNOSIS

The above-named player has been found to HAVE NOT suffered a concussion or other traumatic brain injury and is medically released to return to play immediately in the same game. By signing this form, I acknowledge that I am releasing the above-named player to full return to play with no restrictions and providing a final clearance for said player.

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), 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.

Qualification (MD, DO, ATC, etc.): _____

Signature: _____

Date and Time: _____