Southern Lehigh Youth Baseball
Return to Play Medical Clearance Form

For the Physician: Please indicate your diagnosis and treatment plan below.

Date: ____________

Return to Activity -please check one:

___ I agree the athlete is cleared for unrestricted sports once he/she meets the criteria outlined in this policy.

This includes:
1. Asymptomatic (with no use of medications to mask headache or other symptoms)
2. Completion of Zurich Activity Progression. This may begin once the athlete is asymptomatic for 24 hours.

___ I have different recommendations beyond the above recommendations (please specify):

___ The athlete is to see me again before beginning any physical activity.

Additional comments:

Physician's name (please print): ____

Address: ____

Phone: ____

Physician's Signature: ____

References: ____

1 McCrory et al. Consensus Statement on Concussion in Sport: The 3rd International Conference on Concussion in Sport. ***Journal of Athletic Training*****, 2009: 44(4): 434-448.**