WEST ESSEX REGIONAL SCHOOL DISTRICT

ATHLETIC MEDICAL NOTIFICATION FORM

INJURY NOTIFICATION BY
TREATING PHYSICIAN/LICENSED HEALTH CARE PROVIDER

To the Athletic Department,

As the examining physician or licensed health care provider, trained in the evaluation and management

of concussions, I have examined the following student-athlete or cheerleader, _____.
(Name of Student-Athlete/Cheerleader)

The medical examination conducted on _____ determined the injury:
(Date of Examination)

Check Box (#1 or #2):

☐ 1. Was **not** a concussion or other head injury, the pupil is asymptomatic at rest, and the pupil may

_____ return to school, physical education, and interscholastic athletic activity or cheerleading
(Initial)
programs without restrictions on the following date: _____.
(Clearance Date)

☐ 2. **Was a concussion or other head injury** and the pupil will remain out of physical education and

_____ interscholastic athletic activity or cheerleading programs until further notice. The pupil may
(Initial)
return to school on the following date: _____.
(Date)

Physician's/Licensed Health Care Provider's Stamp:

E-Mail _____
Telephone _____
Fax _____

Physician's/Licensed Health Care Provider's Signature: _____Date: _____

Physician's/Licensed Health Care Provider's Name: (Print Name): _____

Please see attached form if Temporary Accommodations Are Recommended for StudentAthlete/Cheerleader*