GEORGIA SOCCER “RETURN TO PLAY” FORM

(To be signed by the Player’s Parent or Legal Guardian and Returned to UFA Branch Registrar)

By inserting my name and date below, and returning this “Return to Play” Form to the UFA Branch Registrar, I acknowledge that I have read the information contained in the original notification form. I also acknowledge that I am the player’s parent or legal guardian and that I have been advised by Georgia Soccer of common Concussion symptoms, including the requirement in getting professional medical clearance before authorizing my child’s return to play soccer within any Georgia Soccer sanctioned activity.

Please be advised that a player formally identified as suffering a possible concussion injury shall not return to play until the player’s parent or legal guardian confirms that they have a professional medical opinion of their child’s fitness to resume playing before returning this signed authorization to the UFA Branch Registrar.

Player Name [Print]: ____

Player’s Team [Print]: ____

Player’s Affiliate/Club Name [Print]: ____

Age Group & Competitive Division [Print]: ____

Parent/Legal Guardian Name [Print]: ____

Parent/Legal Guardian Signature:___________________________________Date: _____________

Team Official Name [Print]: ____

Team Official Signature:____Date: _____________

STATEMENT OF RELEASE TO RETURN TO PLAY BY GA. LICENCED HEALTH CARE PROVIDER

I have examined the above named player and my professional medical opinion is that he/she is able to return to play [circle one] immediately/graduated participation*

[state period of time] ____

*Attach any supporting documents/prescription.

Ga. Licensed Health Care Provider Name [Print] ____

Ga. Licensed Health Care Provider Signature:__________________________Date: _______________

Ga. License Number (if applicable)____________________Expiration Date: ____________________

Contact Address: ____

Contact Phone: Cell:___________________________Office: ________________________________