HARBORFIELDS CENTRAL SCHOOL DISTRICT

Physician's Note for Concussions

Student's Name: _____ **Date:** _____

Diagnosis: _____

The above captioned patient is:

_____ unable to return to physical education class / athletics (sports) until _____

_____ able to return to physical education class / athletics (sports) on _____

with the following restrictions _____

_____

_____

_____ able to return to physical education / athletics (sports) without any restrictions

_____ unable to return to school (academics) until _____

_____ able to return to school (academics) on _____ with the

following restrictions _____

_____

_____

_____ able to return to school (academics) without any restrictions

Physician's Name: _____

Physician's Signature: _____

Date: _____

Physician Stamp - Required