

**AUTHORIZATION TO RETURN TO PLAY OR PARTICIPATE IN STUDENT SPORTS**

I hereby state that I am a:

\_\_\_\_ Physician licensed pursuant to chapter 18, title 54, Idaho Code.

\_\_\_\_ Physician’s assistant licensed pursuant to chapter 18, title 54, Idaho Code.

\_\_\_\_ Advanced practice nurse licensed under section 54-1409, Idaho Code.

\_\_\_\_ A licensed health care professional trained in the evaluation and management of concussions who is supervised by a directing physician licensed under chapter 18, title 54, Idaho Code. My directing physician is \_\_\_\_\_, his or her license number is \_\_\_\_\_, and address is \_\_\_\_\_.

I have further state that I have met with \_\_\_\_\_ (hereinafter referred to as “student athlete”) to evaluate student athlete for a concussion. I have discussed with student athlete the potential ramifications of continuing to play sports after having received a concussion or exhibiting concussion like symptoms. I am satisfied that student athlete can return to play and/or participate in school athletic leagues or sports without significant likelihood of danger or injury, and I therefore authorize student athlete to return to play and/or participation in school athletic leagues or sports.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
License No.

\_\_\_\_\_  
Address

\_\_\_\_\_  
Signature Directing Physician  
(if signed by a Licensed Health  
Care Professional)

\_\_\_\_\_  
Date