

Athlete: \_\_\_\_\_  
Date of Injury: \_\_\_\_\_  
Today's Date: \_\_\_\_\_  
Sport: \_\_\_\_\_



**Medical Clearance for Return to Athletic Participation  
Following Suspected Concussion or Other Head Injury**

**To be completed by the Authorized Health Care Provider (AHCP)  
(Physician, Nurse Practitioner, Physician's Assistant, Neuropsychologist)**

The above-named student-athlete sustained a suspected concussion or other head injury during a practice or game. The purpose of this form is to provide medical clearance before returning to sports participation, as required by Maryland law.

**I certify that: I am aware of the current medical standards for evaluation and management of concussions and other head injuries. I have examined the above-named child and he/she is cleared to return to play.**

Did the athlete sustain a concussion? Yes \_\_\_ No \_\_\_

Health Care Provider Name \_\_\_\_\_

Signature \_\_\_\_\_

Date: \_\_\_\_\_



**Howard County**  
RECREATION & PARKS

