**MEDICAL RELEASE FOR RETURN TO ATHLETIC PARTICIPATION**

This release is to certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_has been examined

 (Student athlete’s name)

due to exhibiting the signs or symptoms consistent with sudden cardiac arrest. Following an examination, it is my medical opinion that he/she

\_\_\_\_**Is unable to return to participation in athletics until further notice**

 Return appointment scheduled on:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Date)

\_\_\_\_**May return to limited participation in athletics on** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Date)

\_\_\_\_**Following return to limited participation this student needs to return for re-evaluation before being released for full participation in athletics.**

\_\_\_\_**May return to full participation in athletics on**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Date)

**Restrictions:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Health Care Provider’s Name (Type or Print) Date

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Health Care Provider’s Signature Date