SAVE THE BRAIN

RELEASE TO PARTICIPATE FORM

Athlete's Name_____ Date_____

Date of Concussion_____ Return to Play Monitor_____

By signing this form I certify that I am a licensed healthcare provider in the state of Montana and that, per Montana law, I have evaluated this athlete, and in my opinion this athlete is capable of resuming participation in sports activities.

_____ _____

Licensed Healthcare Provider Signature Date

_____ _____

Printed Healthcare Provider Name Office Phone

_____

Office Address

Save the Brain Concussion Clinic (406) 758-7035

logan.org/savethebrain

LOGAN HEALTH