



# MSC CONCUSSION POLICY FORM

## Return to Play

Name of SKATER: \_\_\_\_\_

Date of Sustained Injury(ies): \_\_\_\_\_

Considerations/Restrictions with respect to returning to skate:

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Name of Treating Physician: \_\_\_\_\_ CPSO # \_\_\_\_\_

Signature of Treating Physician: \_\_\_\_\_

Clinic Address: \_\_\_\_\_

Clinic Phone Number: \_\_\_\_\_

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

***Personal information used, disclosed, secured or retained by MSC will be held confidentially and safely for the purpose for which we collected it.***