MFSC 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 MFSC will be held confidentially nd safely for the purpose for which we collected it.