### 2021-22 COVID-19 MEDICAL AUTHORIZATION RETURN TO PLAY FORM

NOTE: This form is **NOT REQUIRED** for use during the 2021-22 school year. It is simply being made available as a tool if local schools/districts elect to utilize it.

I, ____________________________________________, M.D., D.O. or other qualified licensed medical provider,  
(Print name of MD, DO or Other)

have examined the following student:

__________________________________________ from ________________________________________.

(Name of Student) (High School/7th-8th Grade School)

**I have examined this student and determined that he/she is:**

___ Cleared to return to participation

___ Not Cleared and Referred to a cardiologist or other specialist

___ Return to play clearance is limited with the following restrictions:

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

**Signature of Medical Professional:**

__________________________________________________________________________________

(MD, DO or other qualified Licensed Medical Provider as Approved in the Above Directive)

Date: _____________________ Phone: _________________________

Address: __________________________________________

(Print or Stamp Address)

**VALID ONLY WITH ALL INFORMATION COMPLETED**