Abraham Lincoln Memorial Hospital Sportscare Concussion Oversight Team
Post-Concussion Participation Return Consent

Student-athlete name (print): _____ Date of Birth: _____ Age: _____

School: _____

Traumatic Brain Injury/Concussion Date: _____

I, _____ (name of student-athlete or parent/guardian), acknowledge that I or the above-named student-athlete (in the case of the student-athlete being a minor) have/has completed the requirements of the Return-To-Learn and Return-To-Play Protocols and I or the above-named student-athlete (in the case of the student-athlete being a minor) consent to the return to play for the above-named student-athlete. Additionally, I or the above-named student-athlete understand the risks associated with returning to play and returning to learn and will comply with any ongoing requirements in the Return-To-Learn and Return-To-Learn Protocols set forth by a member of the Abraham Lincoln Memorial Hospital Sportscare Concussion Oversight Team or my treating physician. Furthermore, I or the above-named student-athlete consent to the disclosure of any medical records regarding this traumatic brain injury or concussion to any member of the Abraham Lincoln Memorial Hospital Sportscare Concussion Oversight Team upon their request.

_____	_____	_____
Student-Athlete or Parent/Guardian (print)	Student-Athlete or Parent/Guardian (sign)	Date