EL DORADO UNION HIGH SCHOOL DISTRICT

Post-Concussion Release

[MUST BE COMPLETED BY MEDICAL DOCTOR (MD)]

STUDENT NAME	GRADE
SCHOOL	ACTIVITY PARTICIPATING IN

I certify that I have completed the required concussion training and regularly practice in this medical specialty. I have conducted a neurologic screening exam (NSE) or concussion screening evaluation on the above-named student.

I hereby provide full medical clearance for said student to resume participation in the activity/ies listed above.

COMMENTS:

Print Name of MD

Signature of MD

Telephone

Date

Business Address of MD