Post Concussion Physician Release Form

Athletic Training
Department Of Athletics
Weber State University

Athlete's Name ____ Sport _____________________

Date ___________ Date of Injury ____________ ATC's Name_________________________________

1. Zero Score on the "**Graded Symptom Check List**" at rest and following unrestricted exercise
   Date: _____/_____/_____

2. Return to Baseline: **BESS** Test Date: _____/_____/_____

3. Return to Baseline: **"Impact Test"** Date: _____/_____/_____

Notes:

____ Cleared for all sports without restriction

Name of Physician (Print)____

Signature of Physician____ Date: _____/_____/_____