Return to Play – Doctor's Authorization

Please forward to:
Okotoks Minor Hockey Association
Box 1152
Okotoks, Alberta T1S 1B2

DATE: _____
(DAY / MONTH / YEAR)

PATIENTS NAME: _____ MALE/FEMALE (CIRCLE)

D.O.B. _____
(DAY / MONTH / YEAR)

I DECLARE THAT THIS PATIENT IS HEREBY MEDICALLY CLEARED TO RETURN TO HOCKEY WITH

____ NO RESTRICTIONS

____ RESTRICTIONS

FOLLOWING _____(INJURY) INJURIES SUSTAINED on _____, 20 ___.

DESCRIPTION OF RESTRICTIONS (AS REQUIRED)

_____
_____

PHYSICIANS NAME (PRINT) _____
PHYSICIANS SIGNATURE _____
LEGAL GUARDIAN NAME (PRINT) _____
LEGAL GUARDIAN SIGNATURE _____

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