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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