Spokane Youth Sports Association

800 N Hamilton Suite 201 • Spokane, WA 99202
(509) 536-1800 • Fax: (509) 534-0191 • www.sysa.com

SYSA Concussion Release

This form is to be given to the medical provider of a player who exhibited signs or symptoms of a concussion and was evaluated by a medical professional. It is to be completed in full and signed and dated where indicated upon the player being cleared by a medical professional who has received training in the evaluation and management of concussions. The player's parent or guardian should immediately forward any completed form to the SYSA Executive Director at phil@sysa.com or fax: 509.534.0191

Print Player's Full Name

I herby certify that the above named player has been released by me and cleared for full participation to play sports in the SYSA Program without restriction. I further certify that my training as a medical professional included the evaluation and management of concussions.

Print Medical Professional Name Phone Email

Medical Professional Signature Location

Date

<u>This Portion for SYSA Use Only</u>

Received by SYSA Executive Director:

Signature: _____ *Date:* _____