Physician/NP Clearance to Participate

Player Name: _____
Player DOB: _____

Area of injury/diagnosis: _____
Date of Injury: _____

Clearance to participate in unrestricted activity as it relates to hockey including contact practices and games

Yes ☐ No ☐ If NO, please indicate limitations: _____

_____

_____

Physician/NP signature: _____ Date: _____