



Appendix C

Medical Clearance Form

Player's Name: _____

Date of Appointment: DD/MM/YY _____/_____/_____

Medical Practitioner's Name: _____

Diagnosis: _____

Treatment Plan: _____

Expected/Recommended duration of treatment: _____

Is the Player cleared to begin the return to play protocol? Yes No

Is the Player cleared to resume unrestricted soccer? Yes No

If No: Expected Date of Clearance: _____

Conditions of Clearance:

Signed: _____ Date: _____