Coaldale Minor Hockey Association

Return to Play –Significant Injury Doctor's Authorization

DATE: _____
(DD/MM/YYYY)

PATIENTS NAME: _____ MALE/FEMALE (CIRCLE)

D.O.B. _____ _____
(DD/MM/YYYY)

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 _____

Disclaimers Personal information used, disclosed, secured or retained by Coaldale Minor Hockey and Hockey Alberta will be held safely for the purposes for which we collect it and in accordance with the National Privacy Principles contained in the Personal information and Electronic Documents Act as well as Hockey Alberta's own Privacy Policy