

**Rio Grande City CISD  
Athletic Training Department  
“CONCUSSION RELEASE”**

DATE: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Medications: \_\_\_\_\_

The above patient requires:

NO RESTRICTIONS

RESTRICTIONS: \_\_\_\_\_

\_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

\_\_\_\_\_  
Signature/Date

Parents Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Athletic Trainers Signature: \_\_\_\_\_ Date: \_\_\_\_\_