



Return to Play Form: Possible Sudden Cardiac Arrest

This release is to certify that _____ has been examined due to
(Athlete's name)
exhibiting the signs or symptoms consistent with sudden cardiac arrest. Following an examination, it is my
medical opinion that he/she

____ **Is unable to return to participation in athletics until further notice**

Return appointment scheduled on: _____
(Date)

____ **May return to limited participation in athletics on** _____
(Date)

____ **Following return to limited participation this student needs to return for re-evaluation before being
released for full participation in athletics.**

____ **May return to full participation in athletics on** _____
(Date)

Restrictions: _____

Health Care Provider's Name (Type or Print)

Date

Health Care Provider's Signature

Date

*A copy of this document should be provided to the club/ association for which the stated athlete plays and
the governing body of Tennessee State Soccer Association. It may be mailed, emails, or faxed according to
the information below.*

Tennessee State Soccer
100 Country Club Drive, Suite 100
Hendersonville, TN 37075
Email: hhobson@tnsoccer.org
Fax: 615-590-2205
Office: 615-590-2200