Lethbridge Little League Baseball

INJURY RETURN TO PLAY FORM

Player: _____ Coach: _____

Division: _____ Team: _____

Name of Parent/Guardian: _____

Telephone/Email: _____

Division: _____ Team: _____ Coach: _____

Injury Diagnosis (completed by medical professional):

_____

_____

_____

_____

_____

TO WHOM IT MAY CONCERN:

I HAVE EXAMINED THE ABOVE-NAMED ATHLETE AND HEREBY CERTIFY THAT HE/SHE IS CLEARED TO RESUME PLAY IN LITTLE LEAGUE BASEBALL. TO THE BEST OF MY KNOWLEDGE, HE/SHE HAS HAD SUFFICIENT HEALING AND/OR REHABILITATION OF THEIR INJURY TO SAFELY RESUME PLAY WITHIN A REASONABLE DEGREE OF MEDICAL CERTAINTY.

MEDICAL PROFESSIONAL NAME: _____

MEDICAL PROFESSIONAL SIGNATURE: _____

CLINIC:_____

DATE: _____

Completed form must be provided to LLL Safety Officer (safety@lethbridgelittleleague.com) and the team's head coach prior to athlete returning to play.