



MEDICAL & RETURN TO PLAY FORM

Player: _____ Date: _____

Diagnosis (if known): _____

Current Training Status

Modified Reduced Duration Reduced Intensity Not Training

Comments re training modifications: _____

Player can perform the following training tasks with the team (tick all relevant)

Low Level Controlled, lower intensity	<input type="checkbox"/> Warm up <input type="checkbox"/> Jogging	<input type="checkbox"/> Passing <input type="checkbox"/> Other	<input type="checkbox"/> Change of direction drills	<input type="checkbox"/> Shooting
Moderate Level Low level chaos, moderate intensity	<input type="checkbox"/> Warm up <input type="checkbox"/> Contact	<input type="checkbox"/> Change of direction drills <input type="checkbox"/> Team passing and movement drills	<input type="checkbox"/> Strides	<input type="checkbox"/> 1 v 1 Drills
High Level High chaos, high intensity	<input type="checkbox"/> Sprints	<input type="checkbox"/> Scrimmage Drills 2 v 2 etc	<input type="checkbox"/> Matchplay	
Training additions	<input type="checkbox"/> Gym Program <input type="checkbox"/> Other	<input type="checkbox"/> Bike Session	<input type="checkbox"/> Boxing Session	<input type="checkbox"/> Individual rehab program

Target Duration of Training: _____

Relevant for how long: _____

Possible Return to Full Training: _____

Possible Return to Match Participation: _____

Practitioner Name: _____ Date: _____