

The Physician who conducted the return to compete assessment must complete this Form and have it signed by the Skater and her/his Guardian if requested.

Name of the Event

Location

This form confirms that Skater

Family Name

Given Name

Date of Birth – (dd/mm/yy)

after being examined by Doctor _____ has been medically approved by

Doctor _____ to return to full competition.

The diagnosis and follow up treatment have been explained to the Skater (or guardian if under age 16) and has been recorded on the medical record.

Skater Name

Skater Signature

Guardian Name

Guardian Signature

Physician Name

Physician Signature

Designation of Physician at competition: Please check appropriate box.

Chief /Assistant Medical Officer

Team Physician

Date: _____

This Form must be given to the ISU Event Referee / ISU Event Director / Manager

This document must be sent by the ISU Event Referee / ISU Event Director /Manager to the ISU Office at medical@isu.ch