

**West Carleton Skating Club**

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| **RETURN TO SKATE FORM** | |
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| **Revised:** | **June 26, 2016** |
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| **Skater:** |  |
| **Date of Injury:** |  |
| **Coach:** |  |

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| **CONSIDERATIONS/RESTRICTIONS WITH RESPECT TO RETURNING TO SKATE:** |
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| **Name of Treating Physician:** |  |
| **Signature of Treating Physician:** |  |
| **Clinic Address:** |  |
| **Clinic Phone Number:** |  |
| **Date:** |  |

*Personal information used, disclosed, secured or retained by the WCSC will be held in confidentiality and safely for the purpose for which it is collected.*