The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health

POST SPORTS-RELATED HEAD INJURY MEDICAL CLEARANCE AND AUTHORIZATION FORM

The student must be completely symptom free at rest, during exertion, and with cognitive activity prior to returning to full participation in extracurricular athletic activities. Do not complete this form until a graduated return to play plan has been completed and the student is found to be symptom free at rest, during exertion and with cognitive activity.

Student's Name	Sex	Date of Birth	Grade

Date of injury: _____ Nature and extent of injury: _____

Symptoms following injury (check all that apply):

☐ Nausea or vomiting	☐ Headaches	☐ Light/noise sensitivity
☐ Dizziness/balance problems	☐ Double/blurry vision	☐ Fatigue
☐ Feeling sluggish/"in a fog"	☐ Change in sleep patterns	☐ Memory problems
☐ Difficulty concentrating	☐ Irritability/emotional ups and downs	☐ Sad or withdrawn

Duration of Symptom(s): _____ Diagnosis: □ Concussion □ Other: _____

If concussion diagnosed, date student completed graduated return to play plan without recurrent symptoms: _____

Prior concussions (number, approximate dates): _____

I HEREBY AUTHORIZE THE ABOVE NAMED STUDENT FOR RETURN TO ATHLETIC ACTIVITY

Practitioner signature: _____ Date: _____

Print Name: _____

□ Physician □ Licensed Athletic Trainer □ Nurse Practitioner □ Neuropsychologist □ Physician Assistant

License Number: _____

Address: _____ Phone number: _____

Name of Physician providing consultation/coordination/supervision (if not person completing this form; please print):

_____

I ATTEST THAT I HAVE RECEIVED CLINICAL TRAINING IN POST-TRAUMATIC HEAD INJURY ASSESSMENT AND MANAGEMENT APPROVED BY THE DEPARTMENT OF PUBLIC HEALTH* OR HAVE RECEIVED EQUIVALENT TRAINING AS PART OF MY LICENSURE OR CONTINUING EDUCATION.

Practitioner's initials: _____ * MDPH approved Clinical Training options can be found at: www.mass.gov/dph/sports concussion

Type of Training: ☐ CDC on-line Clinician Training
☐ Other MDPH approved Clinical Training
☐ Other (Describe)_____

******This form is not complete without the practitioner's verification of such training.**