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 | □ |
| □ Dizziness/balance problems | □ Double/blurry vision | □ |
| □ Feeling sluggish/”in a fog” | □ Change in sleep patterns | □ |
| □ Difficulty concentrating | □ Irritability/emotional ups and downs | □ |
| □ Other |  |  |

Light/noise sensitivity

Fatigue

Memory problems

Sad or withdrawn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 EXTRACURRICULAR 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: \_\_\_\_\_\_\_

Type of Training:  CDC on-line clinician training Other MDPH approved Clinical Training  Other (Describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* MDPH approved Clinical Training options can be found at: www.mass.gov/dph/sports concussion This form is not complete without the practitioner’s verification of such training.