Mount Greylock Regional School & MA Department of Public Health

POST SPORTS-RELATED HEAD INJURY MEDICAL CLEARANCE AND AUTHORIZATION FORM

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☐ Difficulty concentrating	☐ Irritability/emotional ups and downs	☐ Sad or withdrawn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: _____

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.

The student will not be cleared if the Return to Play information below is not complete.
If concussion diagnosed, date student completed graduated return to play plan without recurrent symptoms: _____

- *Students not involved in an interscholastic athletic program or not currently enrolled in PE must complete the Return to Play Protocol with the physician.*
- *Students involved in one of those programs will be required to complete the attached RTP protocol if no date is listed above.*

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: _____

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.

Revised 6/19/17