The Commonwealth of Massachusetts
Executive Office of Health and Human Services

POST HEAD INJURY MEDICAL CLEARANCE AND AUTHORIZATION FORM

This medical clearance should be only be provided *after* a graduated return to activity plan has been completed and student has been symptom free at all stages. *The student must be completely symptom free at rest and during exertion prior to returning to full participation in extracurricular athletic activities*.

Student's Name	Sex	Date of Birth	Grade

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

Symptoms (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☐ Difficulty concentrating ☐ Irritability/emotional ups and downs ☐ Sad or withdrawn

☐ Other

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

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

Prior concussions: number_____ approximate dates:_____

Name of Physician or Practitioner:_____

□ Physician □ Certified Athletic Trainer □ Nurse Practitioner □ Neuropsychologist

Address: _____ Phone number:_____

Physician providing consultation/coordination (if not person completing this form):

_____

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

Signature: _____ Date: _____

Note: This form may only be completed by: a duly licensed physician; a certified athletic trainer in consultation with a licensed physician; a duly licensed nurse practitioner in consultation with a licensed physician; a duly licensed neuropsychologist in coordination with the physician managing the student's recovery.