



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**

This medical clearance should be only be provided after a graduated return to play 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
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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- Sad or withdrawn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 play 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.