



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/blurred 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- Sad or withdrawn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.*