The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

PRE-PARTICIPATION HEAD INJURY/CONCUSSION REPORTING FORM FOR EXTRACURRICULAR ACTIVITIES

This form should be completed by the student's parent(s) or legal guardian(s). It must submitted to the Athletic Director, or official designated by the school, *prior* to the start of each season a student' plans to participate in an extracurricular athletic activity.

Student's Name	Sex	Date of Birth	Grade
School		Sport(s)	
Home Address			Telephone

Has student ever experienced a traumatic head injury (a blow to the head)? Yes_____ No_____

If yes, when? Dates (month/year): _____

Has student ever received medical attention for a head injury? Yes_____ No_____

If yes, when? Dates (month/year): _____

If yes, please describe the circumstances:

Was student diagnosed with a concussion? Yes_____ No_____

If yes, when? Dates (month/year): _____

Duration of Symptoms (such as *headache, difficulty concentrating, fatigue*) for most recent concussion: _____

Parent/Guardian:
Name: _____ Signature/Date _____
(Please print)

Student Athlete:
Signature/Date _____

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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

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☐ Difficulty concentrating ☐ Irritability/emotional ups and downs ☐ Sad or withdrawn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

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REPORT OF HEAD INJURY DURING SPORTS SEASON

This form is to report head injuries (other than minor cuts or bruises) that occur during a sports season. It should be returned to the athletic director or staff member designated by the school and reviewed by the school nurse.

For Coaches: Please complete this form immediately after the game or practice for head injuries that result in the student being removed from play due to a *possible* concussion.

For Parents/Guardians: Please complete this form if your child has a head injury outside of school related extracurricular athletic activities.

Student's Name	Sex	Date of Birth	Grade
School		Sport(s)	
Home Address		Telephone	

Date of injury: _____

Did the incident take place during an extracurricular activity? _____ Yes ____ No

If so, where did the incident take place? _____

Please describe nature and extent of injuries to student:

For Parents/Guardians:
Did the student receive medical attention? yes_____ no_____
If yes, was a concussion diagnosed? yes____ no _____

I HEREBY STATE THAT TO THE BEST OF MY KNOWLEDGE, MY ANSWERS TO THE ABOVE QUESTIONS ARE COMPLETE AND CORRECT.
Please circle one: Coach or Marching Band Director Parent/Guardian

Name of Person Completing Form (please print): _____

Signature _____ Date _____