

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

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**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 be 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): _____

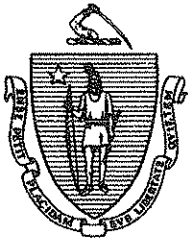
Duration of Symptoms (such as *headache, difficulty concentrating, fatigue*) for most recent concussion: _____

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
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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- Sad or withdrawn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.



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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 _____