WORCESTER PUBLIC SCHOOLS

POST SPORTS-RELATED HEAD INJURY
MEDICAL CLEARANCE AND AUTHORIZATION FORM

The student must be completely symptom-free at rest, during exertion and with cognitive activity prior to returning to full participation in extracurricular athletic activities. Do not complete this form until a graduated return to play plan has been completed and the student is found to be symptom-free at rest, during exertion and with cognitive activity.

Student's Name	Sex	Date of Birth	Grade

Date of Injury _____ Nature and extent of injury _____

Symptoms following injury (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☐ **Difficulty concentrating**	☐ **Irritability/emotional ups and downs**	☐ **Sad or withdrawn**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: _____

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

Practitioner signature: _____ **Date:** _____

Print Name: _____
☐ **Physician** ☐ **Licensed Athletic Trainer** ☐ **Nurse Practitioner** ☐ **Neuropsychologist** ☐ **Physician Assistant**

Address: _____ **Phone number:** _____
Name of Physician providing consultation/coordination/supervision (if not person completing this form; please print

---

I ATTEST THAT I HAVE RECEIVED CLINICAL TRAINING IN POST-TRAUMATIC HEAD INJURY ASSESSMENT AND MANAGEMENT APPROVED BY THE DEPARTMENT OF PUBLIC HEALTH OR HAVE RECEIVED EQUIVALENT TRAINING AS PART OF MY LICENSURE OR CONTINUING EDUCATION

Practitioner's initials: _____

Type of Training: ☐ **CDC on-line clinician training** ☐ **Other MDPH approved Clinical Training** ☐ **Other**

(Please describe) _____
This form is not complete without the practitioner's verification of training.