NATICK PUBLIC SCHOOLS
POST SPORTS-RELATED HEAD INJURY
MEDICAL CLEARANCE AND
AUTHORIZATION FORM

This medical clearance form should be provided ***after*** a student's return-to-play plan has been completed and that it has been determined that the student has been symptom free at all stages. ***The student must be diagnosed as completely symptom free at rest and during exertion prior to returning to full participation in extracurricular athletic activities.****

Student's Name:	Sex:	DOB:
School/Grade:	Date of Injury:	
Nature and extent of injury:		

SYMPTOMS (check all that apply):

- ☐ Nausea or vomiting
- ☐ Dizziness/balance problems
- ☐ Feeling sluggish/"in a fog"
- ☐ Difficulty concentrating
- ☐ Other
- ☐ Headaches
- ☐ Double/blurry vision
- ☐ Change in sleep patterns
- ☐ Irritability/emotional ups and downs
- ☐ Light/noise sensitivity
- ☐ Fatigue
- ☐ Memory problems
- ☐ Sad or withdrawn

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.*

cc: ___School Nurse
___Athletics

January, 2012