The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health

POST SPORTS-RELATED HEAD INJURY MEDICAL CLEARANCE AND RETURN TO PLAY AUTHORIZATION FORM

Student's Name	Sex	Date of Birth	Grade

Date of injury: _____ **Nature and extent of injury:** _____

Prior concussions (number, approximate dates): _____
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- ☐ Sad or withdrawn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: _____

This athlete is symptom free and has passed neurological testing, including the ImPACT test. I, therefore, authorize the above named athlete to begin the graduated return to play protocol with the Braintree Public Schools Athletic Trainer.

Name of Physician or Practitioner:_____

Address: _____ Phone number: _____

I HEREBY 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.

Physician or Practitioner signature: _____ **Date:** _____
Please indicate type of clinical training received (optional):
☐ DPH Clinical Training ☐ On-line Training ☐ Other (Describe)_____

The athlete must be completely symptom free at rest and during exertion prior to returning to full participation in extracurricular athletic activities. If athlete develops any symptoms while completing the graduated return to play protocol, the athlete will be referred back to his/her physician for further evaluation.

I certify that the above athlete has fully completed the gradual return to play protocol, set forth by the Braintree Public Schools multidisciplinary team and guidelines from the CDC, with no signs or symptoms on (date) _____.

Physician providing consultation/coordination: _____

Kara Hines, MS, ATC, LAT Signature: _____Date: _____
128 Town Street Braintree, MA 02184 781-848-4000 x2294

*By September 2013, physicians, nurse practitioners, certified athletic trainers, and neuropsychologists providing medical clearance for return to play shall verify that they have received Department-approved training in post traumatic head injury assessment and management or have received equivalent training as part of their licensure or continuing education. This MDPH approved Clinical Training can be found at: www.mass.gov/dph/sports concussion. 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.*