MASSACHUSETTS SCHOOL HEALTH RECORD

PRIVATE PHYSICIAN'S EXAMINATION- Subsequent Evaluations Only

Student's Name_____

Address_____

Date of Birth: _____Date of last complete physical exam: _____

Significant Findings: Hgt._____Wgt._____Blood Pressure_____

Vision Test_____

Hearing Test_____

Postural Screening_____

Significant illness or injuries since last report:

General estimate of health:

Immunization/Boosters (give exact date):

DTP: Varivax:

Td Other:

Medication or treatment orders to be carried out at school:

Restrictions on sports participation or recommended modifications to school program:

Other comments:

_____

Signature, Examining Physician/Nurse Practitioner Date

(11/02)

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

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☐ Difficulty concentrating ☐ Irritability/emotional ups and downs ☐ Sad or withdrawn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