

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: _____

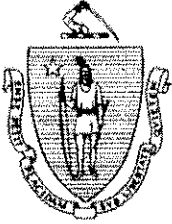
Td _____ Other: _____

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 _____



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/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- Sad or withdrawn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.