Ayer Shirley
Regional School District

115 Washington St.
Ayer, MA 01432
Phone: (978) 772-8600

POST SPORTS RELATED-HEAD INJURY
MEDICAL CLEARANCE AND AUTHORIZATION FORM

After a head injury or suspected concussion and before resuming the extracurricular athletic activity, the student shall submit this form to the Athletic Director or staff member designated by the school. The student must be completely symptom free prior to returning to extracurricular athletic activities. 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.

_____	_____	_____	_____
Student's Name	Sex	DOB	Grade

_____	_____
School	Sport(s)

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 ____	
Withdrawn ____	Other _____	

Duration of Symptom(s): _____

Diagnosis:

☐ Concussion: ____

☐ Other (describe): _____

(Please continue on back for part 2 of this form)

POST SPORTS-RELATED HEAD INJURY MEDICAL CLEARANCE AND AUTHORIZATION FORM (Page 2)

Date Student was determined to be completely symptom free: _____

Graduated return to play instructions or associated limitations to the student's participation in extracurricular athletic activities:_____

_____

_____

_____

Medical management instructions, including recommendations regarding modification of school attendance and/or academic work while student is recovering: _____

_____

_____

_____

_____

Home management instructions:

_____

_____

_____

_____

Physician Name _____

Physician Signature _____ Date _____

I HEREBY AUTHORIZE _____

PRINT STUDENT NAME

FOR RETURN TO EXTRACURRICULAR ATHLETIC ACTIVITY.

Name of Physician or Practitioner (please print): _____

Physician: ___ Certified Athletic Trainer: ___ Nurse Practitioner: ___ Neuropsychologist: ___

Licensee's Address: _____

Licensee's Phone: _____

Name of physician providing consultation or coordination (if not the person completing this form): _____