Carroll School

POST HEAD INJURY
MEDICAL CLEARANCE AND AUTHORIZATION FORM

After a head injury or suspected concussion and before resuming in-school and extracurricular athletic activities, 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 PE/Bounders/recess/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	Gender	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): _____

POST 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 PE/Bounders/recess/extracurricular athletic activities: _____

_____

_____

_____

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

_____

_____

_____

_____

Home management instructions: _____

_____

_____

_____

Name of Licensee:_____

___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):_____

I HEREBY AUTHORIZE THE ABOVE NAMED STUDENT FOR RETURN TO EXTRACURRICULAR ATHLETIC ACTIVITY.

Name of Physician or Practitioner (please print): _____

Signature: _____ Date: _____