The Commonwealth of Massachusetts
Executive Office of Health and Human Services
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Post Sports-Related Head Injury Medical Clearance and Authorization Form

For students: Please have your medical care provider complete this form and return it to your Athletic Director, Athletic Trainer, or School Nurse.

Student Information

Student's name		Date of birth	Grade
Date of injury:	Other relevant diagnosis:		
Asymptomatic: Yes_____No_____	Prior concussions (i.e., Number of concussions, approximate dates):		

Medical Provider Information

Practitioner's name:	Phone number:
Associated Hospital/Organization:	License number:

Type of Practitioner[1]:
☐ Physician ☐ Licensed Athletic Trainer ☐ Physician Assistant
☐ Nurse Practitioner ☐ Neuropsychologist

☐ I attest that I have received clinical training in post-traumatic head injury assessment and management that is approved by the Department of Public Health[2] or have received equivalent training as part of my licensure or continuing education.

Type of Training completed[3]:
☐ CDC online clinician training ☐ MDPH approved Clinical Training ☐ Other (Please describe):

Select one of the following:
☐ I certify that the above named student is cleared to begin a gradual return to play protocol.[4]
☐ I certify that the above named student has completed the necessary stages of a gradual return to play protocol[4] and is cleared for full activity without restriction.

Practitioner's Signature: _____ Date: _____

Name of the physician providing consultation/coordination/supervision (if not the same as signatory):
_____