# CONCUSSION AND HEAD INJURY [AND SERIOUS INJURY] REPORT FORM

| | |
|---|---|
| Student: | School: |
| Grade: | Sport: |
| Date of Incident: | Coach: |

## Concussions and Head Injuries

On _____, the Student listed above was involved in the following incident _____ _____ that may have resulted in him/her suffering a concussion or head injury As a result, the Student was immediately withdrawn from further participation in the listed Sport and will not be allowed to return to practice or participation until a satisfactory medical clearance is provided to the District, which must be provided on the Medical Clearance Form contained on the back of this form.

We urge you to seek prompt medical review and attention, particularly if the Student shows any signs of a concussion or head injury (including headache, pressure in the head, neck pain, nausea or vomiting, dizziness, blurred vision, balance problems, sensitivity to light or sound, feeling "slow," "foggy," or "not right," difficulty with concentration or memory, confusion, drowsiness, irritability or emotionality, anxiety or nervousness, or difficulty falling asleep).

## Other Serious Injuries [For Optional District Use/Recommended but not Legally Required]

**On _____, the Student listed above was involved in the following incident _____ _____ that resulted in an injury considered serious by one or more of the supervising adults. As a result, the Student was immediately withdrawn from further participation in the listed Sport and will not be allowed to return to practice or participation until a satisfactory medical clearance is provided to the District, which must be provided on the Medical Clearance Form contained on the back of this form..**

**We urge you to seek prompt medical review and attention by a medical care provider trained to manage this type of injury**.

Dated: _____

Printed Named of Coach/Supervising Adult: _____

Signature_____

# CONCUSSION AND HEAD INJURY [AND SERIOUS INJURY] MEDICAL CLEARANCE FORM

## PART 1 (COMPLETED BY A PARENT OR LEGAL GUARDIAN)

| LAST NAME | FIRST NAME |
|---|---|
| | |
| **BIRTHDATE** | **STUDENT ID NUMBER** |
| | |

1. Date of last complete physical examination: _____ Performing Physician/Regular Physician:_____

2. Has the Student been seen by any health care provided on an emergency or urgent basis in the last 12-months? ____No ___Yes

3. Has the Student suffered headaches, pressure in the head, neck pain, nausea or vomiting, dizziness, blurred vision, balance problems, sensitivity to light or sound, feeling "slow," "foggy," or "not right," difficulty with concentration or memory, confusion, drowsiness, irritability or emotionality, anxiety or nervousness, or difficulty falling asleep). ____No ___Yes

4. Has the Student suffered from any other symptom, condition, or injury that has, or might, impact his/her ability to safely participate in sports? ____No ___Yes

5. Are you aware of any reason why the Student cannot presently participate safely in athletic training or activity and/or should not receive a full medical clearance to return to athletic activity ? ____No ___Yes

*Explain all "YES" answers, also describing any other fact that should be disclosed prior to the examination):*

**PARENT/GUARDIAN'S AUTHORIZATION:** I authorize the health care provider to perform a Concussion and Head Injury **[and Serious Injury]** Medical Clearance Evaluation. I must provide an appropriately executed medical clearance to the District before the Student can potentially return to athletic practice or participation. The information above is true and correct to the best of my knowledge.

| PRINT NAME OF PARENT OR GUARDIAN | SIGNATURE OF PARENT OR GUARDIAN | |
|---|---|---|
| | | |
| ADDRESS | WORK PHONE | HOME PHONE |
| | | |

## PART 2 – MEDICAL EVALUATION (COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER)

By law, post-concussion/head injury releases must be conducted by a MD/DO, who must represent on the release that they (1) have completed the required concussion training and (2) regularly practice in this medical specialty. *Ed. Code Section 49475.* By signing this Form, the MD/DO represents that they comply with this law.

**MDs, Dos, P.A.s and N.P.'s may perform Serious Injury Medical Release Evaluations**

| | Normal | Abnormal (Describe) | |
|---|---|---|---|
| **General Evaluation:** Eyes/Ears/Nose/Throat/Skin/ Heart, Lungs, Pulmonary Function/ Abdomen/ Musculoskeletal | | | **Release Determination**<br>☐ Unlimited participation<br>☐ Limited participation/specific sports, events or activities (Describe in Comments Section)<br>☐ Clearance withheld pending further testing/evaluation<br>☐ No athletic participation<br><br>One of the above **MUST** be checked. |
| **Neurologic Screening Exam (NSE)**<br><br>**Concussion/Head Injury Evaluation** | | | |

**Comments:**

| PRINT NAME OF PHYSICIAN | | |
|---|---|---|
| | | |

Original signed medical clearance to be provided to District, with copies maintained by the supervising coach and the District/school office for a period of one (1) year after the end of the Academic Year