Student:
Grade:
Date of h

Concussio

On _____
_____
_____
n

D

P

S

CONCUSSION AI

PART 1 (COM

LAST NAME

BIRTHDATE

1. Date of last complete physical examination:

2. Has the Student been seen by any health car

3. Has the Student suffered headaches, pressur sensitivity to light or sound, feeling "slow," "fo irritability or emotionality, anxiety or nervousn

4. Has the Student suffered from any other sy sports? _____No ___Yes

5. Are you aware of any reason why the Stude a full medical clearance to return to athletic act

Explain all "YES" answers, also describin

PARENT/GUARDIAN'S AUTHORIZATI C
Serious Injury] Medical Clearance Evaluatio
Student can potentially return to athletic practic

PRINT NAME OF PARENT OR GUARDIAN

ADDRESS

PART 2 – MEDICAL E

, post-concussi
(1) have completed the re

MDs, D

General Evaluation:
Eyes/Ears/Nose/Throat/Skin/ H
Lungs, Pulmonary Function/
Abdomen/ Musculoskeletal

Neurologic Screening Exam (

Concussion/Head Injury Eval

Comments:

PRINT NAME OF PHYSICIAN