Sturgis Charter Public School

East
427 Main St
Hyannis, MA 02601
508-778-1782
Fax: 508-775-3163

West
105 West Main St
Hyannis, MA 02601
508-771-2780
Fax: 508-771-1293

Head Injury Medical Authorization and Clearance Form

This medical clearance and authorization form is for documenting medical evaluations following a head injury. This form should only be completed by a licensed medical provider or designee licensed by the State of Massachusetts.

Part One should be completed at the time of diagnosis or as close to it as possible and dated accordingly. The form should then be returned to the athletic director or school nurse. Subsequent visits will be documented on this form as well; therefore it is necessary to date next to the student's current ability. The form should be submitted to the school nurse after every medical evaluation. After the student has completed the graduated re-entry plan successfully, **part two** should be completed by the same licensed provider or designee as part one and returned to the school nurse.

Part One:

Student/Athlete's Name	Sex	Date of Birth	Grade

Date of Injury:	Mechanism/Region of injury (i.e. left frontal lobe/head to head):

Symptoms (check all subjective and objective symptoms):

- ☐ Nausea/Vomiting
- ☐ Headache(s)
- ☐ Light/noise Sensitivity
- ☐ Dizziness/Gait Disturbances
- ☐ Visual Changes
- ☐ Fatigue
- ☐ Sluggish Feeling/"in a fog"
- ☐ Changes to Sleeping Pattern
- ☐ Memory Problems
- ☐ Difficulty Concentrating
- ☐ Irritability
- ☐ Sad or Withdrawn
- ☐ Numbness/tingling
- ☐ Other: _____

Duration of Symptoms: _____ Diagnosis: _____

Please indicate if this is the first injury of this type or how many injuries including this one the student has sustained: _____

ImPACT post-injury testing was performed and results were reviewed: ☐ Yes ☐ No

Student is on complete rest until follow up visit/further evaluation: ☐ Yes ☐ No
If yes, today's date: _____

Student is able to return to school but will require academic accommodations: ☐ Yes ☐ No
If yes, today's date: _____

If yes, please indicate the academic accommodations that will be necessary (see the academic accommodation sheet attached):

Date of next appointment for follow up or further evaluation: ____/____/____

Student was not diagnosed with a concussion or traumatic brain injury and is able to return to school with no restrictions including participation in competitive sports and will not require any academic accommodations:

☐ Yes ☐ No If yes, today's date: _____

Student Athletes:
Student is requiring academic accommodations at this time and will return for re-evaluation as stated above.

☐ Yes ☐ No If yes, today's date: _____

Student will not or will no longer require academic accommodations and may begin the graduated re-entry plan at step one once he/she is performing at their pre-injury academic level as assessed by the student's teachers, guidance team, and school nurse.

☐ Yes ☐ No If yes, today's date: _____
Unless specifically stated below, student will begin graduated re-entry plan at step one:

Please indicate any further instructions below:

I HEARBY STATE I HAVE EVALUATED THE ABOVE NAMES STUDENT AND HAVE COMPLETED THE ABOVE FORM TO THE BEST OF MY ABILITY.
Signature of Physician or Designee: _____ Date: _____
Name (please print): _____
Title (i.e. MD):
Business Address: _____
Business Phone: _____
Supervising Physician (if above named is not a physician or a specialist was consulted):
_____

I ATTEST THAT I HAVE RECEIVED CLINICAL TRAINING IN POST-TRAUMATIC HEAD INJURY ASSESSMENT AND MANAGEMENT APPROVED BY THE DEPARTMENT OF PUBLIC HEALTH OR HAVE RECEIVED EQUIVALENT TRAINING AS PART OF MY LICENSURE OR CONTINUING EDUCATION. Initials: _____

Part Two:
The student has completed the first five steps of the graduated re-entry plan attached and may return to full game play.

☐ Yes ☐ No If yes, today's date: _____

Date student completed step-five of the graduated re-entry plan: _____

If no, please indicate your concerns and further instructions below (e.g. student may not participate in game play until…):

If no, date or time frame in which the student will return for re-evaluation: _____

I HEARBY AUTHORIZE THE ABOVE NAMED STUDENT TO RETURN TO EXTRACURRICULAR ATHLETIC ACTIVITY:
Signature of Physician or Designee: _____ Date: _____

Sturgis Charter Public School
Academic Accommodations
(Please check all that apply)

_____ Complete Rest/No School

_____ No computer use

_____ Half-Days until full days are tolerated

_____ No quizzes/tests or assessments

_____ No written only oral quizzes/tests or assessments

_____ Extra time to complete assessments (please specify how long)

_____ 50% more time for missed assignments

_____ Reduction in homework by about 50%

_____ Provide a copy of class notes and presentations and/or assign a note-taker for the student

_____ Testing out of the classroom in an environment with reduced stimuli

_____ Preferential seating to reduce distraction in the classroom

_____ Use of assistive devices (tape recorder or computer to take notes)

_____ Frequent rest periods

_____ No choir/band practice or music class until sensitivity to sound improves

_____ Other: