

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):

- | | | |
|--|--|--|
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Headache(s) | <input type="checkbox"/> Light/noise Sensitivity |
| <input type="checkbox"/> Dizziness/Gait Disturbances | <input type="checkbox"/> Visual Changes | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Sluggish Feeling/"in a fog" | <input type="checkbox"/> Changes to Sleeping Pattern | <input type="checkbox"/> Memory Problems |
| <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sad or Withdrawn |
| <input type="checkbox"/> Numbness/tingling | | |
| <input type="checkbox"/> 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: