

Student:

Grade:

Date of h

Concussion

On \_\_\_\_\_

\_\_\_\_\_

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# CONCUSSION AI

## PART 1 (COM

LAST NAME

BIRTHDATE

1. Date of last complete physical examination:
2. Has the Student been seen by any health care provider since the injury?
3. Has the Student suffered from headaches, pressure, sensitivity to light or sound, feeling "slow," "foggy," irritability or emotionality, anxiety or nervousness?
4. Has the Student suffered from any other sports injuries?  No  Yes
5. Are you aware of any reason why the Student needs a full medical clearance to return to athletic activities?

*Explain all "YES" answers, also describe*

PARENT/GUARDIAN'S AUTHORIZATION  
[Serious Injury] Medical Clearance Evaluation  
Student can partially return to athletic activities

PRINT NAME OF PARENT OR GUARDIAN

ADDRESS

## PART 2 – MEDICAL

, post-concussion  
(1) have completed the re

MDs, I

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