Elk Grove Unified School District | 2024-2025 | Risk Management Department

CONCUSSION AND HEAD INJURY MEDICAL CLEARANCE

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.

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

Comments:	PHYSICIAN STAMP

PRINT NAME OF PHYSICIAN	PHYSICIAN SIGNATURE	DATE

Original signed medical clearance to be given to the school Athletic Director or Principal, with receipted copies provided to the supervising coach, parents, and the Risk Management Department. Clearances are to be retained for a period of one (1) year after the end of the Academic Year.