

MHS Post Head Injury Medical Clearance Form

Student's Name	Date of Birth	Grade
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Date of injury: _____ History of injury: _____

Diagnosis: Concussion Other: _____

Prior concussions (number, approximate dates): _____

Comments: _____

I HEREBY AUTHORIZE THE ABOVE NAMED STUDENT TO RETURN TO ALL SCHOOL RELATED ACTIVITY INCLUDING ACADEMICS, PHYSICAL EDUCATION CLASSES AND EXTRACURRICULAR SPORTS WITHOUT RESTRICTION

PHYSICIAN SIGNATURE: _____ **Date:** _____

PHYSICIAN NAME _____

Address: _____ Phone number: _____