MHS Post Head Injury Medical Clearance Form

Student's Name		Date of Birth	Grade

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 AII SCHOOL RELATED ACTIVITY INCLUDING ACADEMICS, PHYSICAL EDUCATION CLASSES AND EXTRACURRICULAR SPORTS WITHOUT RESTRICTION

PHYSICIAN SIGNATURE: _____ **Date:** _____

PHYSICIAN NAME_____

Address: _____ Phone number: _____