



**NVUSD**  
NAPA VALLEY UNIFIED SCHOOL DISTRICT

## CONCUSSION HEAD INJURY REPORT FORM AND MEDICAL RELEASE

Student:	School:
Grade:	Sport:
Date of Incident:	Coach:
IMPACT ID Number <i>(provided by school or Athletic Director):</i>	

### **Concussions and Head Injuries**

On \_\_\_\_\_, the Student listed above was involved in the following incident

\_\_\_\_\_

that may have resulted in him/her suffering a concussion or head injury. As a result, the Student was immediately withdrawn from further participation in the listed Sport and will not be allowed to return to practice or participation until a satisfactory medical clearance is provided to the District, which must be provided on the Medical Clearance Form contained on the back of this form.

We urge you to seek prompt medical review and attention, particularly if the Student shows any signs of a concussion or head injury (including headache, 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).

### **Other Serious Injuries [For Optional District Use/Recommended but not Legally Required]**

On \_\_\_\_\_, the Student listed above was involved in the following incident

\_\_\_\_\_

**that resulted in an injury considered serious by one or more of the supervising adults. As a result, the Student was immediately withdrawn from further participation in the listed Sport and will not be allowed to return to practice or participation until a satisfactory medical clearance is provided to the District, which must be provided on the Medical Clearance Form contained on the back of this form..**

**We urge you to seek prompt medical review and attention by a medical care provider trained to manage this type of injury.**

Dated: \_\_\_\_\_

Printed Name of Coach/Supervising Adult: \_\_\_\_\_

Signature \_\_\_\_\_

# CONCUSSION HEAD INJURY REPORT FORM AND MEDICAL RELEASE

PART 1 (COMPLETED BY A PARENT OR LEGAL GUARDIAN)		
LAST NAME	FIRST NAME	
BIRTHDATE	STUDENT ID NUMBER	
IMPACT Identification Number (provided by school or Athletic Director):		
<p>1. Date of last complete physical examination: _____ Performing Physician/Regular Physician: _____</p> <p>2. Has the Student been seen by any health care provided on an emergency or urgent basis in the last 12-months?    ___No    ___Yes</p> <p>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</p> <p>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</p> <p>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</p> <p><i>Explain all “YES” answers, also describing any other fact that should be disclosed prior to the examination):</i></p>  		
<p><b>PARENT/GUARDIAN’S AUTHORIZATION:</b> I authorize the health care provider to perform a Concussion and Head Injury <b>[and Serious Injury]</b> 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.</p>		
PRINT NAME OF PARENT OR GUARDIAN	SIGNATURE OF PARENT OR GUARDIAN	
ADDRESS	WORK PHONE	HOME PHONE
<p><b>PART 2 – MEDICAL EVALUATION (COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER)</b></p> <p>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. <i>Ed. Code Section 49475.</i></p> <p>By signing this Form, the MD/DO represents that they comply with this law.</p> <p style="text-align: center;"><b>MDs, Dos, P.A.s and N.P.’s may perform Serious Injury Medical Release Evaluations</b></p>		
	Normal	Abnormal (Describe)
<p><b>General Evaluation:</b> Eyes/Ears/Nose/Throat/Skin/ Heart, Lungs, Pulmonary Function/ Abdomen/ Musculoskeletal</p> <p><b>Neurologic Screening Exam (NSE)</b></p> <p><b>Concussion/Head Injury Evaluation</b></p>		<p style="text-align: center;"><b>Release Determination</b></p> <p><input type="checkbox"/> Unlimited participation</p> <p><input type="checkbox"/> Limited participation/specific sports, events or activities (Describe in Comments Section)</p> <p><input type="checkbox"/> Clearance withheld pending further testing/evaluation</p> <p><input type="checkbox"/> No athletic participation</p> <p>One of the above <b>MUST</b> be checked.</p>
Comments:		
PRINT NAME OF PHYSICIAN		