



The Commonwealth of Massachusetts
 Executive Office of Health and Human Services
 Department of Public Health
 250 Washington Street, Boston, MA 02108-4619

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

JUDYANN BIGBY, MD
SECRETARY

JOHN AUERBACH
COMMISSIONER

**PRE-PARTICIPATION HEAD
 INJURY/CONCUSSION REPORTING FORM
 FOR EXTRACURRICULAR ACTIVITIES**

This form should be completed by the student's parent(s) or legal guardian(s). It must be submitted to the Athletic Director, or official designated by the school, *prior* to the start of each season a student plans to participate in an extracurricular athletic activity.

Student's Name	Sex	Date of Birth	Grade
School		Sport(s)	
Home Address			Telephone

Has student ever experienced a traumatic head injury (a blow to the head)? Yes _____ No _____

If yes, when? Dates (month/year): _____

Has student ever received medical attention for a head injury? Yes _____ No _____

If yes, when? Dates (month/year): _____

If yes, please describe the circumstances:

Was student diagnosed with a concussion? Yes _____ No _____

If yes, when? Dates (month/year): _____

Duration of Symptoms (such as *headache, difficulty concentrating, fatigue*) for most recent concussion: _____

Parent/Guardian:
 Name: _____ Signature/Date _____
 (Please print)

Student Athlete:
 Signature/Date _____

