CHARLES D. BAKER
Gouvènè

KARYN E. POLITO
Lyetnan Gouvènè

MARYLOU SUDDERS
Sekretè

MONICA BHAREL, MD, MPH
Komisyonè

The Commonwealth of Massachusetts

Biwo Egzekitif Sèvis Sante ak Imen
Depatman Sante Piblik
250 Washington Street, Boston, MA 02108-4619

FÒM PRE-PATISIPASYON POU RAPÒTE CHÒ NAN TÈT/KOMOSYON SEREBRAL POU AKTIVITE EKSTRA-KIRIKILÈ

Se paran(yo) oswa gadyen legal(yo) elèv la ki ta dwe ranpli fòm sa a. Yo dwe remèt li ba Direktè Atletik la oubyen ofisyèl lekòl la te deziyen, *anvan* kòmansman chak sezon yon elèv prevwa li pral patisipe nan yon aktivite atletik ekstra-kirikilè.

Non Elèv la	Fi oswa Gason	Dat nesans li	Klas
Lekòl		Espò(yo)	
Adrès Lakay			Telefòn

Èske elèv la te sibi yon chòk twomatik nan tèt (yon gwo kou nan tèt)? Wi_____ Non_____

Si repons la se Wi, kilè? Dat yo (mwa/ane): _____

Èske elèv la te janm resevwa swen medikal pou yon chòk li te pran nan tèt? Wi_____ Non_____

Si repons la se Wi, kilè? Dat yo (mwa/ane): _____

Si repons la se Wi, tanpri dekri sikonstans yo:

Èske yo elèv la janm resevwa yon dyagnostik komosyon serebral? Wi_____ Non_____

Si repons la se Wi, kilè? Dat yo (month/year): _____

Dire sentòm yo (tankou *maltèt, difikilte pou konsantre, fatig*) pou komosyon serebral li te genyen pou dènye fwa a: _____

Paran/Gadyen:
Non li: _____Siyati/Dat _____
(Please print)

Elè ki Atlèt la:
Siyati/Dat _____

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

The Commonwealth of Massachusetts

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

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 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 _____

THIS FORM SHOWS HAITIAN CREOLE ON THE FRONT AND ENGLISH ON THE BACK