

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

CHARLES D. BAKER
 Gouvènè

KARYN E. POLITO
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 Sekretè

MONICA BHAREL, MD, MPH
 Komisyonè

**RAPO SOU CHOK NAN TET PANDAN
 SEZON ESPO A**

Fòm sa a se pou rapòte chòk nan tèt (anwetan po ki fann oswa ti fwape) ki rive pandan yon sezon espòtif. Yo ta dwe voye li tounen ba direktè atletik oubyen manm estaf lekòl la deziyen epi nès lekòl la ta dwe konsilte li.

Pou Antrenè yo: Tanpri ranpli fòm sa a touswit aprè match oswa antrenman an pou chòk nan tèt kifè yo wete elèv la nan match la akòz yon komosyon serebral *potansyèl*.

Pou Paran/Gadyen yo: Tanpri ranpli fòm sa a si pitit ou te pran yon chòk andeyò aktivite atletik ekstra-kirikilè ki andeyò lekòl la.

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

Dat chòk la: _____

Èske ensidan an te rive pandan yon akivite ekstra-kirikilè? ____ Wi ____ Non

Si repons la se Wi, kikote ensidan an rive? _____

Tanpri dekri tip ak gravite chòk elèv la pran:

Pou Paran/Gadyen yo:

Èske elèv la te resevwa swen medikal? wi _____ non _____

Si repons la se Wi, èske yo te dyagnostike yon komosyon serebral? wi _____ non _____

PALAPREZANT, MWEN DEKLARE DAPRÈ TOUT SA MWEN KONNEN, REPONS MWEN BAY POU KESYON KI ANLÈ YO KONPLÈ AK KÒRÈK.

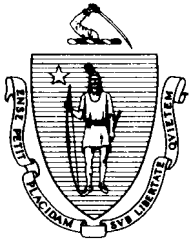
Tanpri antoure yon sèl repons: Antrenè oswa Direktè Bann Fanfa a

Paran/Gadyen

Non Moun k ap Ranpli Fòm lan (tanpri ekri an majiskil): _____

Siyati _____

Dat _____



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

CHARLES D. BAKER
 Governor

KARYN E. POLITO
 Lieutenant Governor

MARYLOU SUDDERS
 Secretary

MONICA BHAREL, MD, MPH
 Commissioner

**REPORT OF HEAD INJURY DURING
 SPORTS SEASON**

This form is to report head injuries (other than minor cuts or bruises) that occur during a sports season. It should be returned to the athletic director or staff member designated by the school and reviewed by the school nurse.

For Coaches: Please complete this form immediately after the game or practice for head injuries that result in the student being removed from play due to a *possible* concussion.

For Parents/Guardians: Please complete this form if your child has a head injury outside of school related extracurricular athletic activities.

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

Date of injury: _____

Did the incident take place during an extracurricular activity? ____ Yes ____ No

If so, where did the incident take place? _____

Please describe nature and extent of injuries to student:

For Parents/Guardians:

Did the student receive medical attention? yes ____ no ____

If yes, was a concussion diagnosed? yes ____ no ____

I HEREBY STATE THAT TO THE BEST OF MY KNOWLEDGE, MY ANSWERS TO THE ABOVE QUESTIONS ARE COMPLETE AND CORRECT.

Please circle one: Coach or Marching Band Director

Parent/Guardian

Name of Person Completing Form (please print): _____

Signature _____

Date _____