SWEETWATER UNION HIGH SCHOOL DISTRICT

SCHOOL REFERRAL TO A HEALTH EVALUATION FOR CONCUSSION SYMPTOMS

Schools to retain a copy of completed form before sending to doctor

DATE: _____

TO: **California-licensed Health Care Provider**

FROM: **Staff Member making referral:**

Position: ___ Nurse ___ Coach ___ Athletic trainer ___ Health Tech ___ Principal Other _____

RE: **Student Name:** _____ **Birthdate:** _____

School_____ **Grade:**_____ **Teacher or Room:**_____

I the parent/guardian authorize release of information about concussion and management, between this school and student's physicians:

Name:_____ _____

(Signature of Parent or Guardian) (Printed Name of Parent or Guardian)

Dear Licensed Health Care Provider,

This student was noted to have these symptoms or signs after an injury (either immediately or minutes / hours after):

___Dizziness / "seeing stars" ___Temporary loss of consciousness ___ Confusion/foggy feeling___ Nausea ___ Vomiting

___ Amnesia around event ___Light or noise sensitive ___ Ringing in ears ___Slurred speech___ Delayed response to questions ___ Appeared dazed ___ Fatigue ___ Concentration/memory problem___ Irritability or personality change

___*Headache/pressure feeling in head (**if attributable to cut, bruise, then inadequate alone to diagnose concussion).*

OR: Standardized Concussion Assessment attached to this form (e.g., SCAT)

The injury occurred on _____ (*date*) at approximately _____ (*time*).

Details of injury that occurred are (i.e., *which sport/activity, part of head or body hit, nature of object, force etc.*):_____

Witness(es) to the injury and/or to signs/symptoms of concussion were (check all that apply):

☐ Staff members (n*ame and locations*):_____

☐ Fellow athletes (*no names*) ☐ Injured student's self-report ☐ Injured student's parent/guardian ☐ Other_____

NOTE: Students suspected of having a concussion must have a graduated 'return-to-play' protocol of no less than seven days in duration under supervision of a licensed health care provider (MD or DO). Input regarding the medical examination today and medical management plans are requested by this school. Attached is a: Return to Learn and/or Return to Play form for you (or another physician) to complete.

To be completed by examining physician:

☐ Student was evaluated and **did not** have a concussion injury. **There are no limitations on school and physical activity.**

I have reviewed the above history of concussion symptoms and concur that a concussion occurred or is likely to have occurred and I prescribe following:

☐ **Recommended standard for initial treatment:** First day after injury, stay home, cognitive rest, no physical activity. Once student tolerates a 15 minute walk without symptoms, can begin school with a half-day the first day back, and full days as tolerated thereafter.

Attached see completed: ☐ **Return to Learn Instructions** ☐ **Return to Play* instructions** [*Ed Code 49475 & 35179.5, MD or DO; 7-day minimum*] ☐ I will follow this patient myself or ☐ Patient to be followed by :_____ (*Name of primary care doctor or specialist)*

_____ _____ _____ _____

Printed Name of Examining Clinician *Signature of Examining Clinician* *Date* *Telephone No*

_____

Doctor's Stamp *(Name of Clinic / Address of Clinician)*

THIS COMPLETED FORM MUST BE REURNED TO SCHOOL NURSE IMMEDIATELY UPON THE STUDENTS RETURN TO SCHOOL