



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 (immediately or within hours): 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 (names and locations): \_\_\_\_\_
Fellow athletes (no names) Injured student's self-report Injured student's parent/guardian Other \_\_\_\_\_

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.

Head Injury - Parent Notification form (page 2 - provides warning signs of subdural hematoma)

To be completed by examining physician: 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)

PLEASE return this form to:

Printed Name: \_\_\_\_\_

School or Address: \_\_\_\_\_

Tel: \_\_\_\_\_ \*\* FAX \_\_\_\_\_

Signature of Examining Clinician \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Examining Clinician \_\_\_\_\_

Telephone No. \_\_\_\_\_

Name of Clinic / Address of Clinician \_\_\_\_\_



HEAD INJURY - PARENT NOTIFICATION

Dear Parent:

Today, \_\_\_\_\_ received an injury to the head.  
(Name of Student)

Your child was seen in the health office. For head injuries, you should watch for any of the following symptoms:

- Severe headache.
- Excessive drowsiness (awaken child at least twice during the night) or difficulty in rousing child.
- Nausea and/or vomiting.
- Double or blurred vision, or pupils of different sizes.
- Loss of muscle coordination such as falling, staggering, or walking strangely.
- Any unusual behavior such as being confused, irregular breathing, or being dizzy.
- Convulsion (seizure).
- Bleeding or unusual fluid coming from ear, nose, or mouth.

If you notice any of the above symptoms, **contact your doctor or emergency room at once.**

LESIONES EN LA CABEZA - NOTIFICACION A LOS PADRES

*Estimados Padres:*

*Hoy, \_\_\_\_\_ recibió un golpe en la cabeza.  
(Nombre Del Estudiante)*

*Su niño/a fue revisado en la Enfermería Escolar. Usted debe observar su niño/a por si se presenta(n) los siguientes síntomas:*

- *Dolor de cabeza severo.*
- *Somnolencia excesiva, (despierte el niño/a por lo menos dos veces durante la noche), o si tiene dificultad para despertarlo/a.*
- *Nausea y/o vómito.*
- *Vista doble o borrosa, o diferentes tamaños de pupila.*
- *Pérdida de coordinación de músculo como caerse, tambalearse o caminar en forma extraña.*
- *Comportamiento extraño como confusion, respiración irregular o vértigos.*
- *Convulsiones. (Ataques)*
- *Sangrado o líquido excepcional por el oído, la nariz o la boca*

***Por favor consulte inmediatamente a su médico o sala de emergencias si usted nota alguno de estos síntomas***

\_\_\_\_\_  
School Staff's Signature/ Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
School

\_\_\_\_\_  
Telephone Number