REPORT OF STUDENT'S HEAD INJURY

Date: _____ Grade: _____

Dear Parent/Guardian:

This is to inform you that your child _____ has suffered a suspected head injury.

The following event occurred: _____

_____

_____

Location of injury: _____ Time: _____

The signs and symptoms of concussion can show up right after an injury or may not appear or be noticed until hours or days after even a minor injury. Be alert for any of the following signs or symptoms. Also, watch for changes in how the student is acting or feeling, if symptoms are getting worse, or if the student just "doesn't feel right."

The following symptoms were noted:

SIGNS OBSERVED BY TEACHERS AND SCHOOL PROFESSIONALS	SYMPTOMS REPORTED BY THE STUDENT	
☐ Appears dazed or stunned ☐ Is confused about events ☐ Shows behavior or personality changes ☐ Can't recall events prior to the hit, bump, or fall ☐ Can't recall events after the hit, bump, or fall ☐ Repeats questions ☐ Loses consciousness (even briefly) ☐ Answers questions slowly	Thinking/Remembering: ☐ Difficulty thinking clearly ☐ Concentrating or remembering ☐ Feeling sluggish, hazy, foggy, or groggy Emotions: ☐ Irritable, sad, nervous	Physical: ☐ Headache or "pressure" in head ☐ Nausea or vomiting ☐ Balance problems or dizziness ☐ Fatigue or feeling tired ☐ Blurry or double vision ☐ Sensitivity to light or noise ☐ Numbness or tingling ☐ Does not "feel right"

DANGER SIGNS with head injury

Be alert for symptoms that worsen over time. Your child or teen should be seen in an emergency department right away if s/he has:

- One pupil (the black part in the middle of the eye) larger than the other
- Drowsiness or cannot be awakened
- A headache that gets worse and does not go away
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Difficulty recognizing people or places
- Increasing confusion, restlessness, or agitation
- Unusual behavior, hyperactivity
- Loss of consciousness (even a brief loss of consciousness should be taken seriously)
- Weakness of either arm or leg
- Blood or clear fluid dripping from ears or nose.(Do not blow a bloody nose or attempt to clean blood from ears or nose.)
- Slowing of pulse or rapid and weak
- A change in temperature
- Stiffness of neck

Seek medical attention right away. A health care professional experienced in evaluating head injury and concussion can determine how serious the injury is and when it is safe for your child or teen to return to normal activities including physical activity and school (concentration and learning activities). Be sure to bring a note from the doctor for any restrictions.

Disposition:

☐ Unable to contact Parent by telephone
☐ Symptoms noted (circled above)
☐ Child went home with parent/guardian
☐ Reviewed above by phone with_____
☐ Child returned to class
☐ No symptoms notes
☐ Child to ER via EMS

School: _____ School Phone #: _____

Teacher Signature: _____ and/*or* Nurse Signature: _____

Parent/Guardian Signature _____ Date: _____

Principal/Department Head signature: _____ Date: _____

Original to Principal **Copy to Student Services** **Copy to Parent** **Copy to School Nurse**

Haywood County Schools

Consent for Release of Information

Student name: _____ Date of Birth:_____

I hereby authorize: (Name of facility) _____

(Address) _____

(City, State, zip) _____

To release information to: (Name of School) _____

Attention: _____

(Address) _____

(City, state, zip) _____

Phone: _____ Fax: _____

Yes/No This consent to release information about the above named student is reciprocal.

Please send:

___ Screenings

___ Evaluations

___Admission Assessment

___Plans for care

___Progress notes

___Other _____

I understand the contents to be released, the need for the information, and that the confidentiality of this information will be protected under FERPA legislation. This consent is valid for a period of one year with the understanding that it can be revoked at any time at my written request.

Date: _____

Signature of parent/guardian: _____

Printed name of parent/guardian: _____

Relationship to student: _____

Concussion Return-To-Learn Recommendations

(To be completed by Licensed Physician (MD/DO) or an LAT, PA, or NP under treating physician's supervision)

Name of Athlete: _____ **Date:** _____

Following a concussion, most individuals typically need some degree of cognitive and physical rest to facilitate and expedite recovery. Activities such as reading, watching TV or movies, playing video games, working/playing on the computer and/or texting require cognitive effort and can worsen symptoms during the acute period after concussion. Navigating academic requirements and a school setting present a challenge to a recently concussed student-athlete. A Return-To-Learn policy facilitates a gradual progression of cognitive demand for student-athletes in a learning environment. Healthcare providers should consider whether academic and school modifications may help expedite recovery and lower symptom burden. It is important to the review academic/school situation for each student athlete and identify educational accommodations that may be beneficial.

Educational accommodations that may be helpful are listed below.

Return to school with the following supports:

Length of Day

__ Shortened day. Recommended ____ hours per day until re-evaluated or (date) _____.
__ ≤ 4 hours per day in class (consider alternating days of morning/afternoon classes to maximize class participation)
__ Shortened classes (i.e. rest breaks during classes). Maximum class length of _____ minutes.
__ Use _____ class as a study hall in a quiet environment.
__ Check for the return of symptoms when doing activities that require a lot of attention or concentration.

Extra Time

__ Allow extra time to complete coursework/assignments and tests.
__ Take rest breaks during the day as needed (particularly if symptoms recur).

Homework

__ Lessen homework by _____ % per class, or _____ minutes/class; or to a maximum of _____ minutes nightly, no more than _____minutes continuous.

Testing

__ No significant classroom or standardized testing at this time, as this does not reflect the patient's true abilities.
__ Limited classroom testing allowed. No more than _____ questions and/or _____ total time.
    __ Student is able to take quizzes or tests but no bubble sheets.
    __ Student able to take tests but should be allowed extra time to complete.
__ Limit test and quiz taking to no more than one per day.
__ May resume regular test taking.

Vision

__ Lessen screen time (SMART board, computer, videos, etc.) to a maximum _____ minutes per class AND no more than _____ continuous minutes (with 5-10 minute break in between). This includes reading notes off screens.
__ Print class notes and online assignments (14 font or larger recommended) to allow to keep up with online work.
__ Allow student to wear sunglasses or hat with bill worn forward to reduce light exposure.

Environment

__ Provide alternative setting during band or music class (outside of that room).
__ Provide alternative setting during PE and/or recess to avoid noise exposure and risk of injury (out of gym).
__ Allow early class release for class transitions to reduce exposure to hallway noise/activity.
__ Provide alternative location to eat lunch outside of cafeteria.
__ Allow the use of earplugs when in noisy environment.
__ Patient should not attend athletic practice
__ Patient is allowed to be present but not participate in practice, limited to ___ hours

Additional Recommendations:

_____

_____

_____

Medical Provider Concussion Evaluation Recommendations

(To be completed by Licensed Physician (MD/DO) or an LAT, PA, or NP under treating physician's supervision)

Name of Athlete: _____ **Date of Evaluation:** _____

All NC public high school and middle school student-athletes must have a Licensed Physician's (MD/DO) signature on the ***Return to Play Form: Medical Clearance Releasing the Student-Athlete to Return to Athletic Participation*** *prior to them returning to play. Due to the need to monitor concussions for recurrence of signs & symptoms with cognitive or physical stress, Emergency Room and Urgent Care physicians should not not make clearance decisions at the time of first visit.* All medical providers are encouraged to review the CDC site if they have questions regarding the latest information on the evaluation and care of the scholastic athlete following a concussion injury. *Providers should refer to NC Session Law 2011-147, House Bill 792 Gfeller-Waller Concussion Awareness Act for requirements for clearance, and please initial any recommendations you select.* (Adapted from the Acute Concussion Evaluation (ACE) care plan (http://www.cdc.gov/concussion/index.html) and the NCHSAA concussion Return to Play Protocol Form.)

The recommendations indicated below are based on today's evaluation.

RETURN TO SCHOOL:

PLEASE NOTE

1. The North Carolina State Board of Education approved "Return-To- Learn after Concussion" policy effective 2016-2017 school year to address learning and educational needs for students following a concussion.
2. A sample of accommodations is found on the **Concussion Return to Learn Recommendations** page.

SCHOOL (ACADEMICS): (Physician identified below should check all recommendations that apply.)

- ☐ Out of school until _____.
- ☐ May return to school on _____ with accommodations selected on the **Concussion Return to Learn Recommendations** page.
- ☐ May return to school now with no accommodations needed.

RETURN TO SPORTS:

PLEASE NOTE

A step-by-step progression of physical and cognitive exertion is widely accepted as the appropriate approach to ensure a concussion has resolved, and an athlete can return to sport safely. The **NCHSAA Concussion Return to Play Protocol** has been designed using a step-by-step progression.

SPORTS & PHYSICAL EDUCATION (Physician identified below should check all recommendations that apply.)

- ☐ Not cleared for sports or physical education at this time.
- ☐ May do light physical education that poses no risk of head trauma such (i.e. walking laps).
- ☐ May start RTP Protocol under appropriate monitoring.
- ☐ Must return to examining physician for clearance before returning to sports/physical education.
- ☐ Has completed a gradual RTP Protocol without any recurrence of symptoms. The **RETURN TO PLAY FORM** has been completed and signed by the Licensed Physician releasing the student-athlete to full participation.

Physicians may choose to delegate aspects of the student-athlete's care to a physician practice based licensed athletic trainer, licensed nurse practitioner or licensed physician assistant who is working under that physician's supervision, and may work in collaboration with a licensed neuropsychologist in compliance with the Gfeller-Waller Concussion Law for RTP clearance. * If this option is chosen, that individual should be designated by completing the requested information at the bottom of this page *.

_____ Date _____

Signature of Physician Licensed to Practice Medicine MD / DO

_____

Please Print Name

Office Address _____ Phone Number _____

Physician signing this form is licensed under Article 1 of Chapter 90 of the General Statutes and has training in concussion management.

**** The physician above has delegated aspects of the student-athlete's care to the individual designated below *.***

_____ Date _____

Signature of Physician Practice Based LAT, NP, PA-C, Neuropsychologist (Please Circle)

_____

Please Print Name

Office Address _____ Phone Number _____

Last Updated January 2017