Head Trauma Notification Letter

Name:	DOB:	Date of HT:	Mechanism of HT:
School:	Grade:	School Nurse:	ATC:
Psych/Counselor:		Teacher:	
Parent(s)	Phone:	Address:	

Dear Licensed Practitioner,

Your student/athlete, Type student name, has sustained a head injury/concussion on Type date.

- For a non-sports related concussion, Type school district name invites you to participate in the treatment and management of this concussion.
- For a sports related concussion, per CHSAA Bylaw #1790-21: "If at any time during participation, a student-athlete is removed from participation due to head trauma, the student-athlete must obtain a written release from a licensed practitioner before participating again. A school or school district may impose stricter standards."

In accordance with Best Practice and CHSAA, Type school district name is alerting you to this injury and requesting that you partner with us in the management and recovery of this student/athlete.

At the time of this notification, symptoms are:

Physical Symptoms						**Cognitive Symptoms**		
	At time of injury	___# Hrs Post		At time of injury	___ # Hrs Post		At time of injury	___ # Hrs Post
Headache/Pressure	☐	☐	Nausea	☐	☐	Feel in a "fog"	☐	☐
Blurred Vision	☐	☐	Vomiting	☐	☐	Feel "slowed down"	☐	☐
Dizziness	☐	☐	Numbness/Tingling	☐	☐	Difficulty remembering	☐	☐
Poor Balance	☐	☐	Sensitivity to Light	☐	☐	Difficulty concentrating/easily distracted	☐	☐
Ringing in Ears	☐	☐	Sensitivity to Noise	☐	☐	Slowed speech	☐	☐
Seeing "stars"	☐	☐	Disorientation	☐	☐	Easily confused	☐	☐
Vacant stare/Glassy eyed	☐	☐	Neck Pain	☐	☐			
Emotional Symptoms						**Sleep/Energy Symptoms**		
Inappropriate emotions	☐	☐	Irritability	☐	☐	Fatigue	☐	☐
Personality change	☐	☐	Sadness	☐	☐	Excess sleep	☐	☐
Nervousness/ Anxiety	☐	☐	Lack of Motivation	☐	☐	Trouble falling asleep	☐	☐
Feeling more "emotional"	☐	☐				Drowsiness	☐	☐
						Sleeping less than usual	☐	☐
Other:								

Type school district name abides by the Community-Based Concussion Management protocol. This Community-Based Concussion Management protocol requires that family, school and licensed practitioner partner together to manage the concussion by consensus. As we collect data at school, we greatly appreciate collaborating with you on important return-to-play/return-to-learning decisions. Before you make any definitive decisions regarding this student/athlete, we ask that you please contact the Concussion Manager on this case: Type case manager's name Phone:Type phone number for symptom report, postural-stability assessments and cognitive data and that you coordinate your follow-up care with the student/athlete's school. The Release of Information is signed below:

_____

Signature of Parent or Guardian

I approve reciprocal communication between Type school district nameand Medical Practice.

Licensed Practitioner Name:_____

Address:_____ Phone:_____

_____ Fax: _____

Attachment(s): _____

CHSAA, 7/2010

THE FOLLOWING INFORMATION MUST BE COMPLETED BY THE LICENSED PRACTITIONER AND RETURNED TO THE SCHOOL DISTRICT PRIOR TO RETURN TO ACTIVITY:

Name:	DOB:	Date of HT:	Mechanism of HT:
School:	Grade:	School Nurse:	ATC:
Psych/Counselor:		Teacher:	
Parent(s)	Phone:	Address:	

Treatment Plan Date: _____

☐ Asymptomatic. Cleared to start a gradual/stepwise return to play protocol supervised by a certified athletic trainer.

☐ Symptomatic. Not cleared.

- ☐ Follow up recommended
- ☐ May start a gradual/stepwise return to play protocol supervised by a certified athletic trainer ***once asymptomatic***

Additional Comments: _____

Licensed Practitioner Signature: _____Date;_____

Facility Name: _____ Facility/Contact Number: _____

Treatment Plan Date: _____

☐ Asymptomatic. Cleared to start a gradual/stepwise return to play protocol supervised by a certified athletic trainer.

☐ Symptomatic. Not cleared.

- ☐ Follow up recommended
- ☐ May start a gradual/stepwise return to play protocol supervised by a certified athletic trainer ***once asymptomatic***

Additional Comments: _____

Licensed Practitioner Signature: _____Date;_____

Facility Name: _____ Facility/Contact Number: _____