Provo School District – Secondary Schools
Head Trauma Notification Letter (3422 F1)

School Use Only			
Student's name:	DOB:	Date of HT:	Mechanism of HT:
School:	Grade:	School Nurse:	
Psych/Counselor:		Teacher:	ATC:
Parent(s)/Guardian(s):	Phone:	Address:	

Dear Licensed Practitioner,

Student/athlete_____sustained a head injury/concussion on _____(date). The student was engaged in the following activity:

_____

_____

_____

In accordance with Provo City School District Policy and Utah Code 26–53–301, we are 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: (make entries for all that apply)

Physical Symptoms						**Cognitive Symptoms**		
	Time of injury	**# hrs. post-injury**		**Time of injury**	**# hrs. post-injury**		**Time of injury**	**# hrs. post-injury**
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 eyes			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:								

-Parent/Guardian Use-

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 school at phone # _____for symptom report, postural-stability assessments and cognitive data. The Release of Information is signed below.

I approve reciprocal communication between Provo School District and Medical Practice.

_____

Signature of Parent or Guardian

-Physician/Medical Personnel Use-

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

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

I, (name) _____have, within three years before today, successfully completed a continuing education course in the evaluation and management of a concussion.

I hereby clear the child to resume participation in (name of sporting event)

_____

_____ _____

Signature Date

_____

Print name