San Diego Unified
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*ames 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.

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