**REQUST FOR EXAMINATION and SYMPTOMS REPORT**
**with**
**PERMISSION FOR RELEASE OF INFORMATION**

Dear Health Care Provider,

________________________________________________has sustained a possible head injury/concussion on this date ________________.

In conjunction with this student's parents, Kutztown Area School District is requesting follow up medical care/clearance.

At the time of this notification, symptoms are as follows:

**OBSERVED BY OTHERS:**

**Thinking/Remembering**

___ Difficulty thinking clearly
___ Difficulty remembering new information
___Forgets events prior to the hit/fall
___ Difficulty concentrating
___ Feeling slowed down
___Forgets events after the hit/fall

**Physical**

___Lost consciousness
___ Headache
___ Dizziness
___ Balance problems
___ Feeling tired, having no energy
___ Blurry vision
___ Sensitivity to noise or light
___ Nausea or vomiting

**Emotional/Mood**

___ Irritability
___More emotional
___Sadness
___Nervousness or anxiety

**Sleep**

___Sleeping more than usual
___Sleeping less than usual
___Trouble falling asleep

Additional Notes:

**SYMPTOMS REPORTED BY STUDENT:**

**Thinking/Remembering**

___Foggy or hazy feeling
___Problems remembering
___Problems concentrating

**Physical**

___Headache or pressure in head
___Double vision, blurry vision
___Balance problems or dizziness
___Nausea or vomiting
___Sensitivity to light or noise
___Numbness or tingling

**Emotional/Mood**

___Feeling nervous, anxious
___Feeling sad

**Sleep**

___Sleep problems
___Feeling sluggish/fatigued

To my knowledge this is this child's ____________concussion.

Additional Notes:

School Nurse Completing this Form: ________________________________________________

Date ______________________

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I approve reciprocal communication between Kutztown Area School District and the physician caring for my child.

Signature of Parent or Guardian ____________________________________________________

Date ______________________

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Physican diagnosis of the above named student:

___No evidence of concussion
___Concussion

Licensed Health Care Provider Signature___________________________________________

Licensed Health Care Provider Print Name _________________________________________

Date _______________________

Address ____________________________________________________________________________

Phone Number_____________________________________________________

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**If this child has been diagnosed with a concussion the*Concussion Accommodations Plan Form*should be completed and returned to school for guidance with future physical, emotional and academic activities.**