MEDICAL PROVIDER: FAX form to (970) 245-0825 (School District #51 only)

Western Colorado Concussion Alliance
Head Injury – Notification to School

School District 51 MESA COUNTY VALLEY
Every student, every day, learning for life!

This form should be completed at the patient/student's first contact with a medical professional. This information is confidential and intended only for the school based traumatic brain injury team, members of this patient's educational team, and the school's athletic trainer if applicable.

PARENT OR AUTHORIZED AGENT complete this section AND have medical provider FAX to school

REQUEST TO RELEASE OR SECURE CONFIDENTIAL INFORMATION

Legal Name of Patient (print): _____ Date of Patient's Birth: _____

Parent or Authorized Agent Name (print): _____ **Patient's School:** _____

☐ To: School Nursing Coordinator **FAX: (970) 245-0825 (School District #51 only)** Dist. 51 Phone: (970) 254-5417

☐ To:_____ School District #_____ FAX:_____ School Phone: _____

I request and authorize the following health care provider(s) and the appropriate staff and/or athletic trainer of my child's school checked above to receive and provide information related to the head injury specified below for the purpose of providing notification and awareness and limitations related to the described head injury. This authorization to disclose is strictly voluntary and the permitted disclosure may be made pursuant to this request.

Emergency Center providing initial assessment: _____

Patient's Primary Care Physician: _____

Other Health Care Provider: _____

I understand that:

1. I may revoke this authorization at any time by providing notification in writing, but if I do it will not have any effect on any actions taken prior to receiving the revocation.
2. The released information gathered, compiled, and stored by the school staff becomes classified as educational records and, therefore, is protected under the Family Educational Rights and Privacy Act and the Colorado Open Records Law.

My signature is required to validate this Authorization. If I do not sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected.

_____	_____	_____	_____
Date	Signature of Parent or Authorized Representative	Relationship to patient	Contact Phone Number

EXPIRATION: Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 360 days from the date hereof, unless otherwise specified as follows:

OTHER CONDITIONS: A copy or facsimile of the Authorization with my signature may be used with the same effectiveness as an original.

MEDICAL PROVIDER ASSESSMENT. Medical Provider complete this section and FAX form to school indicated above

Patient Name: _____ Date of Birth: _____

Date of Injury: _____ Mechanism of Injury: _____

☐ 1. This student has suffered a concussion. Please make academic adjustments as needed because this student is recovering from a concussion. As the patient's symptoms resolve, please advance academic accommodations as tolerated. As per Colorado Law, if this student is involved in an organized youth athletic activity (public or private interscholastic, team, club, league, or other entity) now or at any time during the school year, they must be released by a health care provider for return to play.

☐ 2. This student suffered a concussion but their symptoms have resolved and they have been cleared by a health care provider to start a graded return to play protocol prior to full medical release for all interscholastic athletes.

☐ 3. This student has no evidence of concussion. This student did not have and currently does not have symptoms consistent with a concussion.

☐ 4. This student has suffered a closed head injury with symptoms at the time of injury consistent with concussion. This student needs further evaluation by a health care provider with concussion management training.

Notes:

_____

_____

Health Care Provider signature: _____ Date: _____

Health Care Provider printed name:_____ Phone: _____ Fax:_____