KENNEWICK SCHOOL DISTRICT

Concussion Documentation

Completed by Health Care Provider

Student Photo

Name: Birth Date:

Diagnosis:_____

Brief description of condition:_____

_____

How would this current condition adversely affect student's educational performance?_____

_____

Instructions from HCP: ***(activity, classroom, school bus, field trips, disaster, etc.)***

__ May return immediately to school full time.
__ Not to return to school. May return on (date) _____
__ Return to school with supports as checked below. Review on (date) _____
- __ Shortened day. Recommended ____ hours per day until (date) _____
- __ No participation in P.E. or Weight Conditioning class until *_____
- __ May participate with restrictions in P.E. or Weight Conditioning class (list) *_____
- __ No significant classroom or standardized testing at this time.
- __ Other: List _____

(*will need Health Care Provider clearance to remove restrictions)

While student is recovering, until symptoms improve, accommodations may include:

1) Adjusting academic expectations as student recovers, provide work that doesn't require a lot of concentration. Allowing extra time to complete educational or physical tasks. Provide a process for obtaining notes for class material if needed. Student may have problems with paying attention, concentrating, remembering or learning new information. Know testing at this time may not give an accurate assessment of the student's abilities.
2) Send with a buddy to the health room if appears to feel tired to be allowed to rest.
3) Understand the student may be irritable and less able to cope with stress.
4) Provide an environment that is not over stimulating with noise/light.
5) Limit computer/screen time.
6) Consider passing time not with the general population and preferably with a buddy.
7) Will call parent for all head bumps regardless how mild.

Action Plan: If sending student with head injury symptoms anywhere, send with an escort

Mild Symptoms – Allow to rest or take med if ordered	**Moderate Symptoms – Call parent to go home, to follow-up with Dr.**	**Serious Symptoms - Call 911**
• Mild nausea • Mild headache • Mild dizziness • Mild tiredness	• Increased dizziness/sleepiness • Headache worsens • Vomiting • Possible behavior changes • Weakness of face or limbs or decreased coordination • Increased confusion	• Eye/pupil changes • Repeated vomiting • Cannot keep eyes open • Seizure or any loss of consciousness • Slurred speech • Paralysis of limb

Health Care Provider Signature:	Date:
Health Care Provider name (print or type)	
Phone:	Fax:
School Nurse Signature:	Date:

Date Reviewed with Parent/Nurse Signature:

AUTHORIZATION FOR MUTUAL RELEASE OF RECORDS

Kennewick School District Nursing Services

Purpose: *As a parent, guardian or student, you have the right to give permission or not give permission for the release of your child's records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the Family Education Right and Privacy Act. FERPA, (for example, transfer of records from one school district to another).*

Student Name: _____ Date: _____ DOB: _____

I hereby authorize the release of records

From:		***To:***	
Agency/Person:		**Agency/Person:**	***KSD Nurse***
Street Address:		**Street Address:**	
City, State, Zip:		**City, State, Zip:**	***Kennewick, WA,***
Tel:	***Fax:***	***Tel: 509-222-***	***Fax: 509-222-***

Describe the records to be disclosed: _Diagnoses, medication and any medical recommendations that are applicable for the student at school._

The reason for disclosing the record(s) is: To provide safe care of the student in the educational setting.

I understand that this information obtained will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards by a school district and not the Health Insurance Portability and Accountability Act (HIPAA).

This authorization is valid from _____/_____/_____ **to** _____/_____/_____**.**

I understand that my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

_____

Parent/guardian/student signature Date