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PERMISSION FOR RELEASE OF INFORMATION

School District:

Name of School:

Address:

Phone:

Dear Healthcare Provider,

\_\_\_\_\_ has sustained a head injury/concussion on this date \_\_\_\_\_. Once a student exhibits signs, symptoms or behaviors consistent with concussion following an observed or suspected blow to the head or body or has been diagnosed with a concussion, a certified athletic trainer or coach may allow that member to participate in an athletic event or training only after the athlete:

- a) No longer exhibits signs, symptoms or behaviors consistent with a concussion **and**
- b) Receives a medical release form from a healthcare professional.

School District \_\_\_\_\_ is alerting you to the injury and requesting that you partner with them in the management and recovery of this student athlete.

At the time of this notification, symptoms are:

SIGNS (OBSERVED BY OTHERS):	SYMPTOMS (REPORTED BY ATHLETE):
<input type="checkbox"/> Athlete appears dazed or stunned	<input type="checkbox"/> Headache or pressure in head
<input type="checkbox"/> Seems confused	<input type="checkbox"/> Foggy or hazy feeling
<input type="checkbox"/> Forgets plays or instructions	<input type="checkbox"/> Nausea or vomiting
<input type="checkbox"/> Is unsure about game, score, opponent	<input type="checkbox"/> Double vision, blurry vision
<input type="checkbox"/> Moves clumsily (altered coordination)	<input type="checkbox"/> Sensitivity to light or noise
<input type="checkbox"/> Exhibits balance problems	<input type="checkbox"/> Feeling sluggish, fatigued or groggy
<input type="checkbox"/> Shows changes in mood, behavior or personality	<input type="checkbox"/> Problems concentrating
<input type="checkbox"/> Responds slowly to questions	<input type="checkbox"/> Problems remembering
<input type="checkbox"/> Forgets events prior to hit or fall	<input type="checkbox"/> Just not feeling right or feeling down
<input type="checkbox"/> Forgets events after the hit or fall	<input type="checkbox"/> Balance problems or dizziness
<input type="checkbox"/> Loses consciousness (even briefly)	<input type="checkbox"/> Numbness or tingling
	<input type="checkbox"/> Sleep problems

We greatly appreciate collaborating with you on important return to activities decisions. The Release of information is signed below. *NOTE: The healthcare provider's own form may be substituted for this one.*

I approve reciprocal communication between <school district> and <Medical Practice>. At any time I may end this agreement.

\_\_\_\_\_  
Signature of Parent or Guardian

Licensed Healthcare Provider \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_