SAMPLE RELEASE OF INFORMATION FORM

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 STUDENT):
<u>Physical</u> Moves clumsily (altered coordination) Exhibits balance problems Loses consciousness (even briefly) <u>Cognitive</u> Appears dazed or stunned Seems confused Forgets plays or instructions Is unsure about game, score, opponent Responds slowly to questions Forgets events prior to hit or fall Forgets events after the hit or fall <u>Emotional</u> Shows changes in mood, behavior, or personality	<u>Physical</u> Headache or pressure in head Nausea or vomiting Double vision, blurry vision Sensitivity to light or noise Feeling sluggish, fatigued, or groggy Balance problems or dizziness Numbness or tingling <u>Cognitive</u> Problems concentrating Problems remembering Foggy or hazy feeling <u>Emotional</u> Just not feeling right or feeling down <u>Sleep problems</u> Difficulty falling or staying asleep Sleeping less than usual

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_____

Adapted from
Oregon Concussion and Management Program (OCAMP) and
Slocum Sports Concussion Program