Procedure 614-JLCE
Revision B
Effective 4-01-17

ST. VRAIN VALLEY SCHOOLS
academic excellence by design

MANAGING CONCUSSIONS

Athletics and Activities / Risk Management / Student Services

ST. VRAIN VALLEY SCHOOL DISTRICT
Longmont, CO

TABLE OF CONTENTS

MANAGING CONCUSSIONS

1. SCOPE

This document defines procedures to be used in caring for victims of concussions in St. Vrain Valley School District.

1.1. APPLICATION

This procedure is applicable to all employee caregivers, victims, and those in charge of events in which a possible concussion has occurred.

The requirements of Board Policy JLCE govern. This document also provides processing procedures not specified in Board Policy JLCE.

2. CONFLICT STATEMENT

Notify the Executive Director of Student Services of any conflict between the requirements of this procedure and any other applicable policies and procedures. The conflict shall be resolved, with changes as negotiated. If in conflict with Board of Education policies, Board of Education policies shall prevail.

3. DOCUMENT CONTROL

Submit change requests for this procedure to the Executive Director of Student Services who then shall determine the appropriate action. Reference 700-2 Create and Change Standard Operating Procedures (SOPs) for change procedures. The Executive Director of Student Services shall have final approval for revision to this procedure.

3.1. RESPONSIBILITY FOR ENFORCEMENT

Compliance with the requirements of this procedure is the responsibility of Student Services with support from Athletics and Activities, and Risk Management.

4. COMMUNICATION PLAN REQUIREMENTS

A mandatory communication plan to brief all persons or functions affected by the creation or change in this procedure has been added to the Appendix. This plan includes a list of actions, person responsible, and due dates.

The effective date of this procedure (indicated at the top of the cover page) shall not be before the completion of the communication plan. Approval of the communication plan by the Assistant Superintendent of Operations by initialing the latest revision is required before approval of the procedure.

5. REFERENCE DOCUMENTS

The current issues of the following documents form a part of this procedure to the extent specified herein, and/or are listed here as additional sources of information:

5.1. ST. VRAIN VALLEY SCHOOL DISTRICT

Board Policy JLCE	First Aid and Emergency Medical Care
BrainSTARS	Lash & Associates Publishing/Training Inc.
C.R.S 25-43-101	Jake Snakenberg Youth Concussion Act
REAP The Benefits of Good Concussion Management	Rocky Mountain Youth Sports Institute

CDE Concussion Management Guidelines
http://www.cde.state.co.us/HealthAndWellness/BrainInjury.htm

6. DEFINITIONS

6.1. CONCUSSION

A concussion is a traumatic brain injury that changes the way the brain works. It is a trauma-induced alteration in mental status. Concussions can be caused by a direct blow to the head or an indirect blow which causes the brain to "bounce" against the inside of the skull. Confusion and memory problems are the hallmark of concussions, but headache, nausea, vomiting, dizziness, ringing in the ears, and visual disturbance also are common.

6.2. HEALTH CARE PROVIDER

A health care provider is a licensed physician, licensed nurse practitioner, licensed physician's assistant, licensed doctor of osteopathic medicine, or licensed doctor of psychology.

7. INTRODUCTION

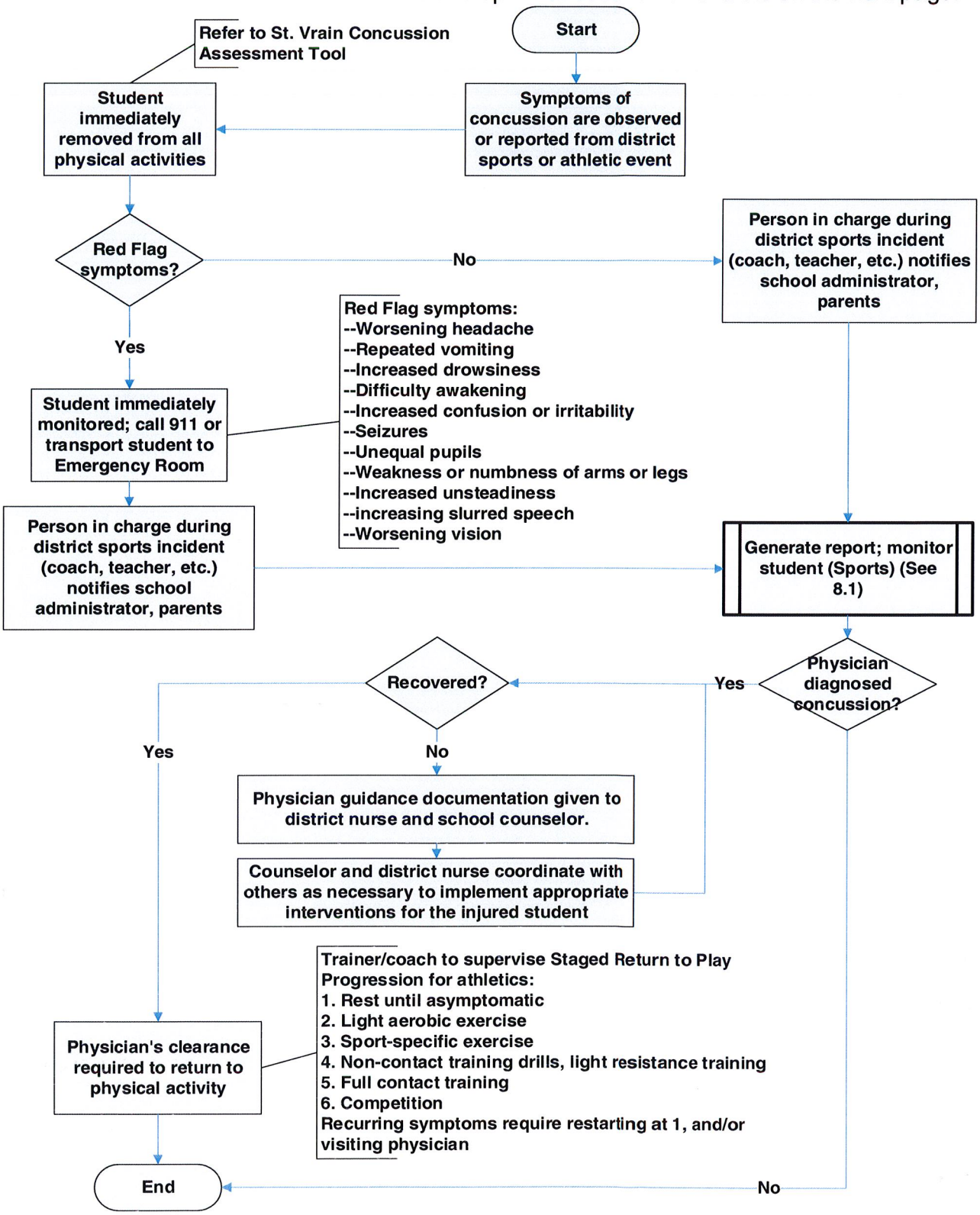
This procedure describes what school district employees should do to help protect students and help them heal after they suffer concussions. There is more information in the Health Services internet website at http://www.svvsd.org/files/Health%20Services%20Information%20and%20Forms/concussion.pdf, or from the web site, under departments, select Health Services, select Health Information/Forms, select concussion information.

Computerized neurocognitive tests are not approved for use in SVVSD schools. These tests, used to assess an athlete's neurocognitive functioning pre-concussion and then again at regular intervals post-concussion, are not mandated, and present logistical and liability challenges to a school district.

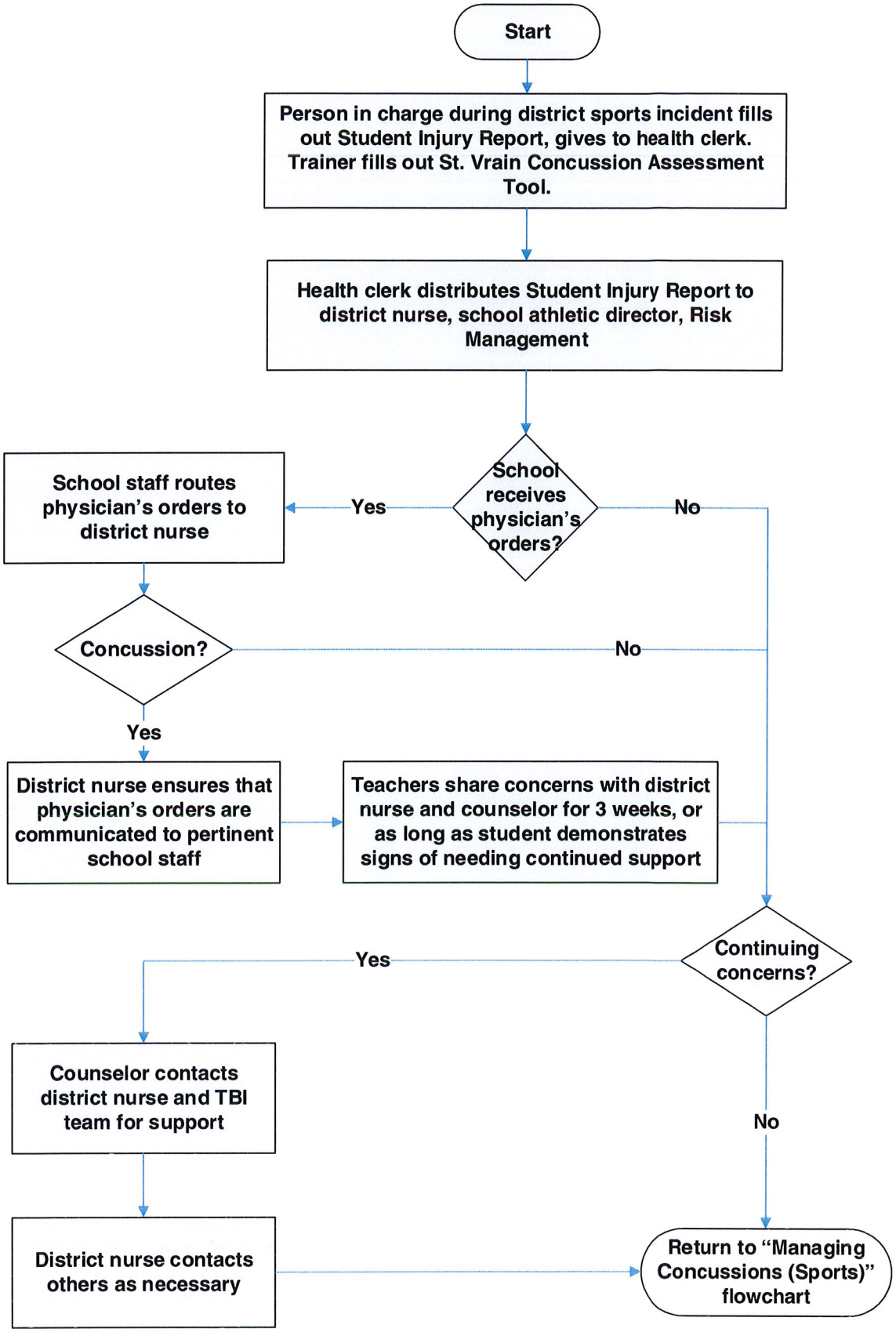
All of the required forms are included in this procedure, except for the Student Injury Report. That report is available on the Risk Management website at http://svvsd.org/files/STUDENT%20INJURY%20REPORT.pdf or from the Human Resources department web page, select Risk Management/Workers' Comp, select Student Injury Report.

8. MANAGING CONCUSSIONS (SPORTS RELATED)

The following flowcharts describe steps that must be taken to protect students after a concussion. This first flowchart deals with district sports-related concussions. In the first flowchart, the step, Generate report; monitor student (Sports Related) (see 8.1), has a double border. This means there is another flowchart that describes that step. That second flowchart is on the next page.

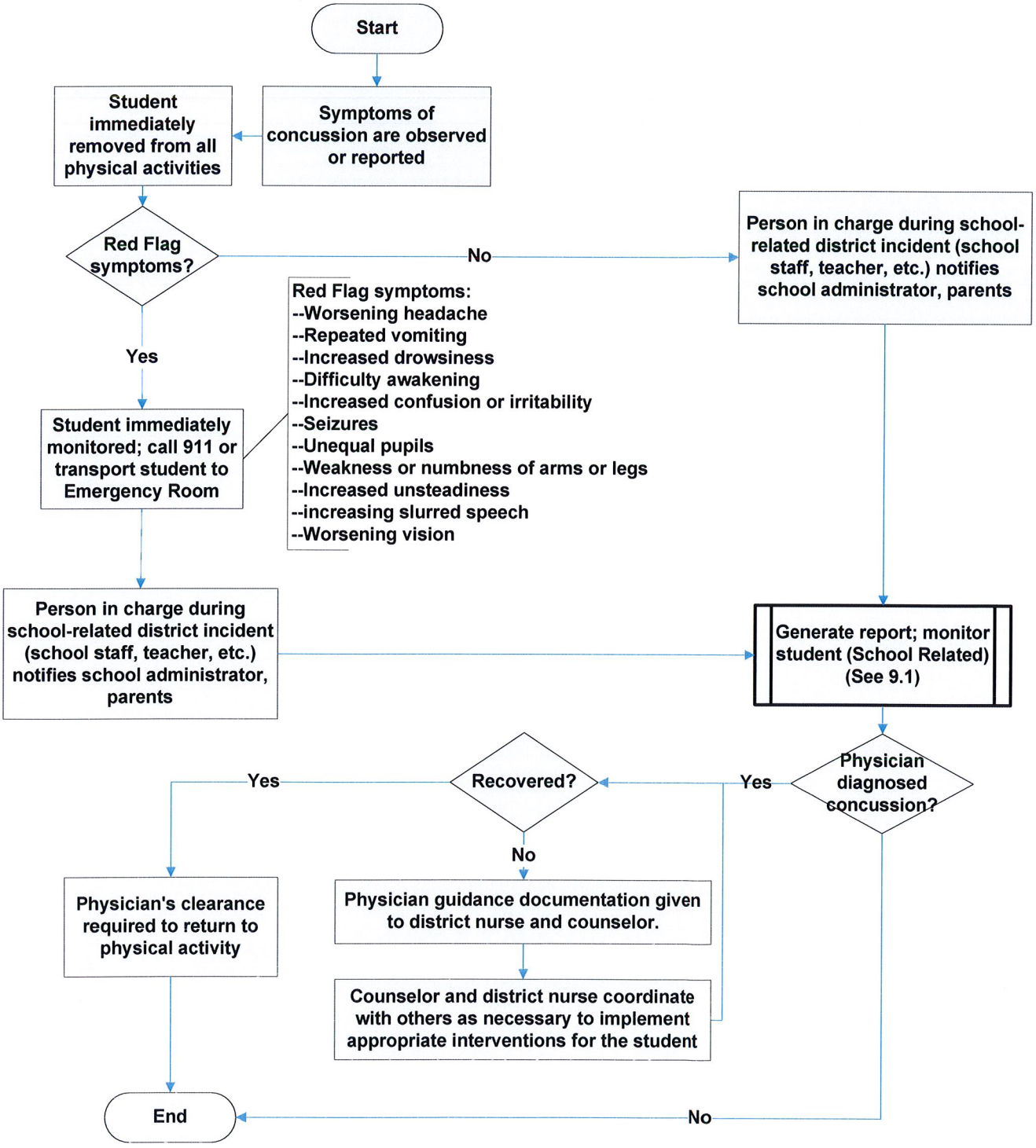


8.1. GENERATE REPORT; MONITOR STUDENT (SPORTS)

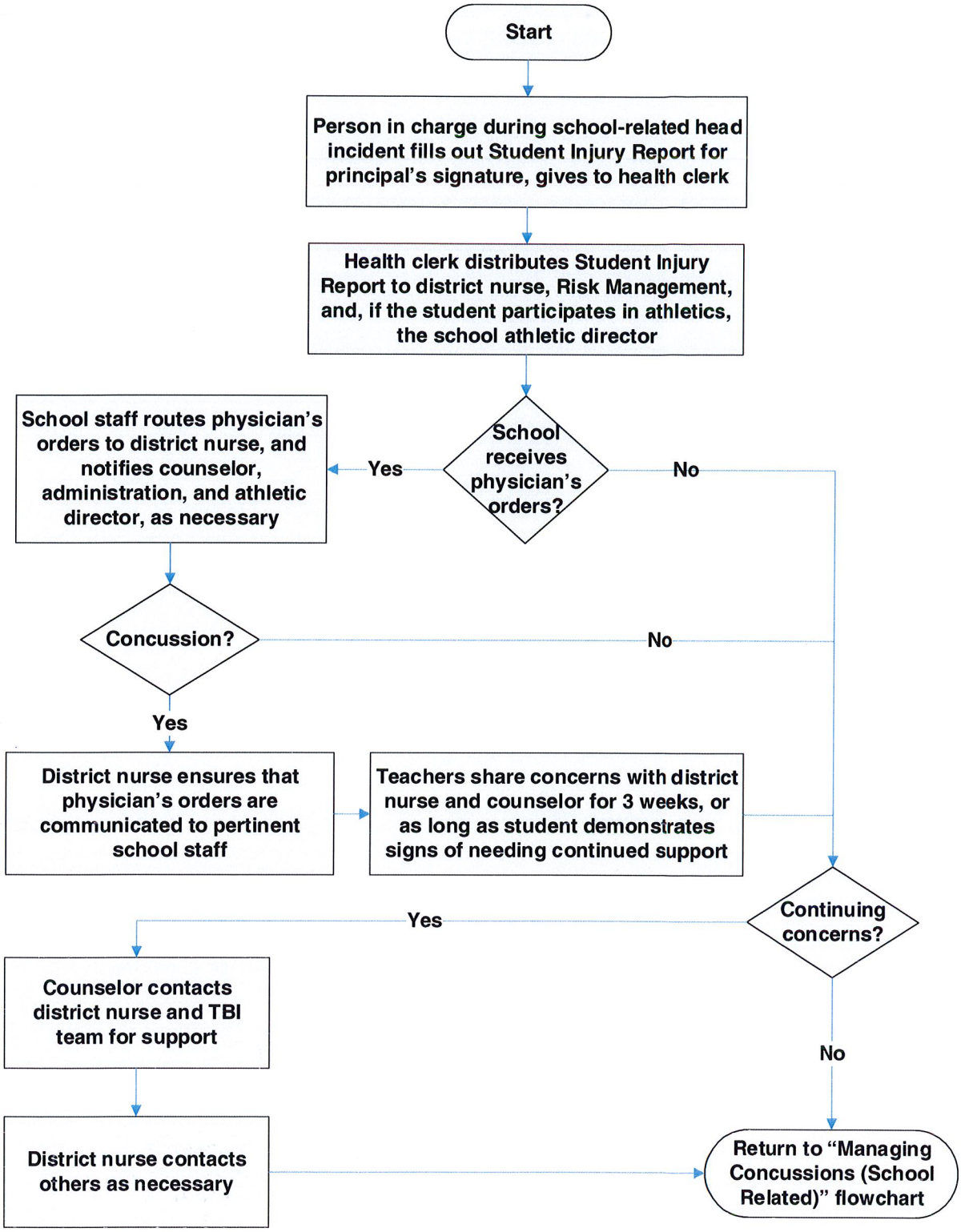


9. MANAGING CONCUSSIONS (SCHOOL RELATED)

This flowchart shows the steps that must be taken to protect students after a school-related concussion that might not be related to organized sports.

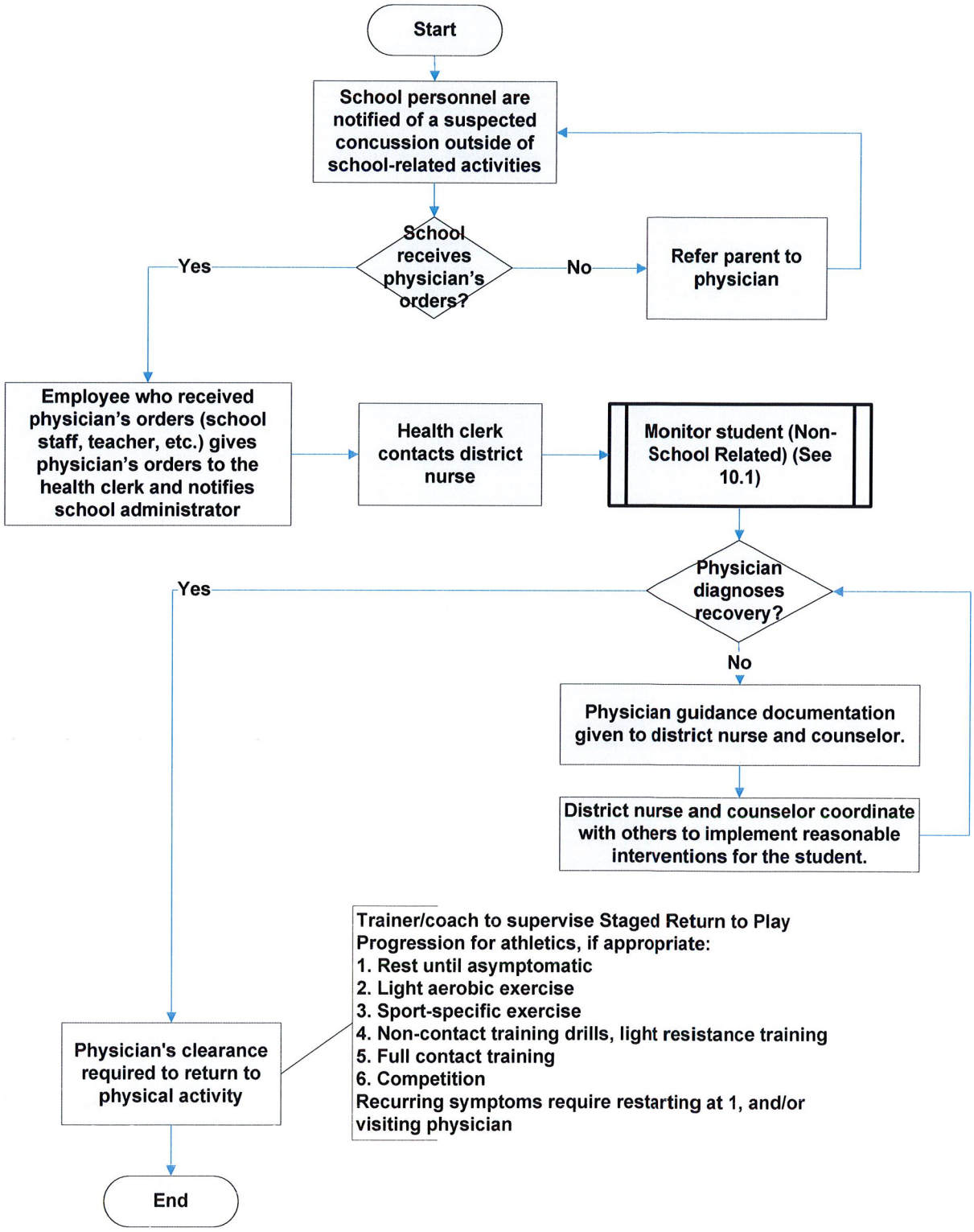


9.1. GENERATE REPORT; MONITOR STUDENT (SCHOOL RELATED)

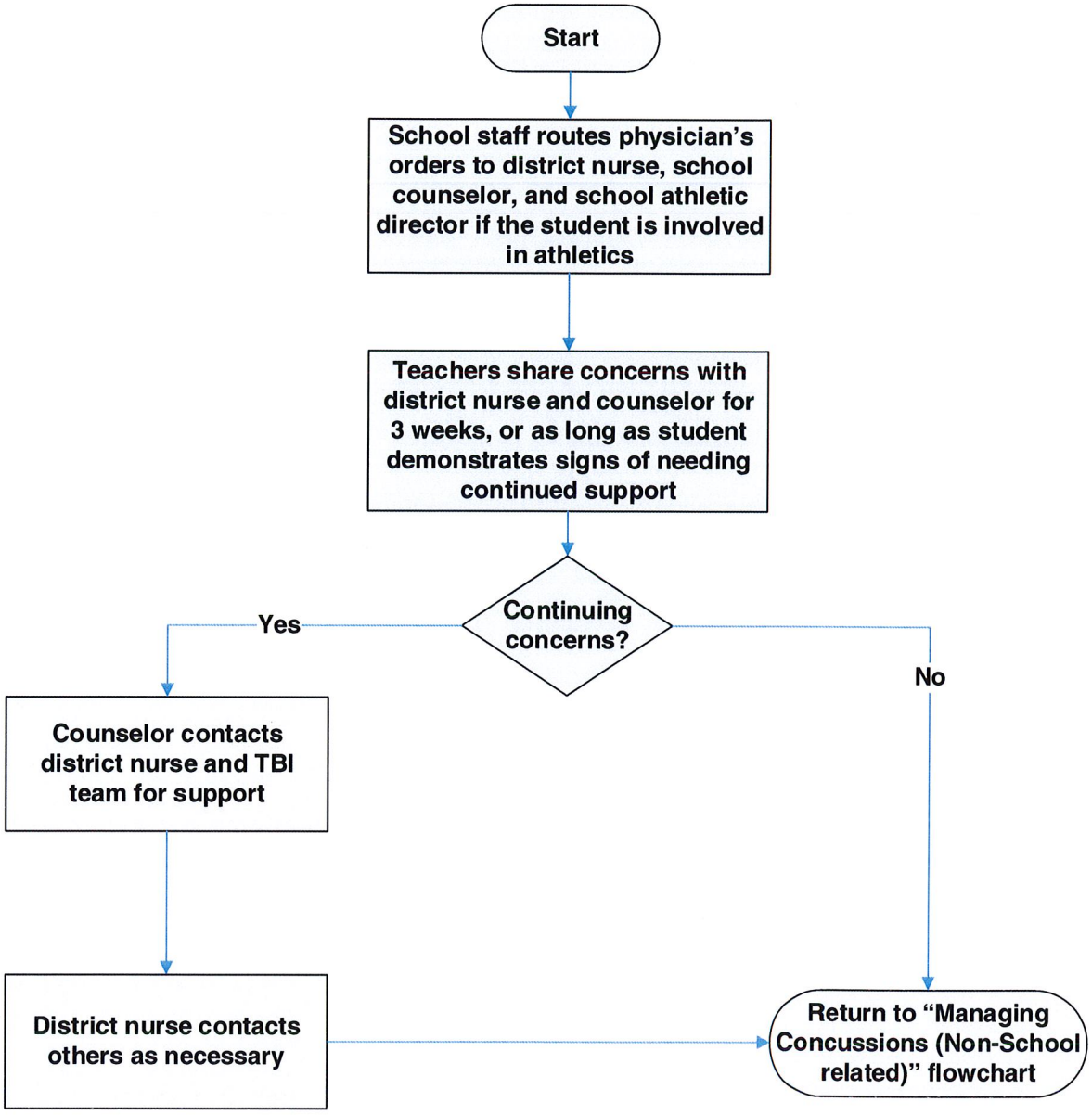


10. MANAGING CONCUSSIONS (NON-SCHOOL RELATED)

This flowchart shows the steps that must be taken to protect students after a non-school-related concussion that did not occur during school district activities. Examples would be incidents during non-district-sponsored club sports, accidents at home, etc.



10.1. MONITOR STUDENT (NON-SCHOOL RELATED)



11. ROLES AND RESPONSIBILITIES

This section briefly reviews the roles and responsibilities of all district staff to help a student with symptoms of a concussion. These lists might not be all-inclusive, and responsibilities might be shared at times.

11.1. COACHES AND TRAINERS

a. Coaches complete annual concussion training required by statute. Link to online training option: http://www.cdc.gov/headsup/youthsports/training/
b. Coaches or trainers notice any sign of concussion or witness forceful blow to the head.
c. Remove athlete from all physical activities and begin monitoring for red flag symptoms.
d. If there are red flag symptoms, call 911 or transport student to emergency room.
e. Notify building administrator and work with building administrator to communicate with parents.
f. Coaches and trainers communicate with school AD, school staff, and district nurse as needed.
g. Signed clearance from a physician required before student can return to physical activity.
h. Trainer/coach will supervise Staged Return to Play Progression.
i. Recognize that students cannot return to play if they are unable to participate in learning activities successfully.

11.2. BUILDING ADMINISTRATORS

a. When notified that a student has symptoms of a concussion, work with person in charge during incident and district nurse to organize communication with parents.
b. Follow through to make sure the proper protocols are followed to monitor and care for the student until cleared by the physician to return to learning/physical activity.

11.3. DISTRICT NURSE

a. If on site during incident, collaborate with staff to assess Red Flag symptoms (Red Flag symptoms are listed in the procedure flow charts).
b. When notified that a student has a physician-diagnosed concussion, collaborate with the building administrator, staff, and parents as necessary.
c. Receives Student Injury Report Form from health clerks.
d. If student is displaying symptoms and the school hasn't received documentation of a medical evaluation, the nurse will encourage parents to seek medical evaluation of the student.
e. Receives physician concussion document and shares with pertinent staff.
f. Receives release of information (HIPPA form) from parents, if necessary, to collaborate with physician.
g. District nurse contacts others as necessary.
h. Notified of physicians' clearance to return to school/physical activities and shares with pertinent staff.

11.4. HEALTH CLERKS

a. If notified by a student or parent that a concussion happened outside of school, complete a student injury report and send to Risk Management and district nurse.
b. Receives student injury report from staff for incidents occurring during school, school events, or athletics. Distributes completed student injury report form to Risk Management and district nurse.
c. If student comes to the health office manifesting symptoms, the health clerk should contact the district nurse.

d. Receives physician concussion documentation and forwards it to counselor, teachers, athletic director (if student is in sports), and district nurse.
e. Uploads physician concussion documentation into Infinite Campus.

11.5. DISTRICT ATHLETIC DIRECTOR (AD)
a. If sports-related, works with school AD, coach, and trainer as necessary.

11.6. SCHOOL ATHLETIC DIRECTORS (AD)
a. Receives physician concussion guidance document from health clerk if the student participates in athletics.
b. Consults with coach, trainer, and district AD as necessary.
c. Recognize that students cannot return to play if they are unable to participate in learning activities successfully.

11.7. COUNSELORS
a. Notified that a student might have a concussion.
b. Receives physician's orders and confers with appropriate parties.
c. Contact district nurse and Brain Injury Resource Team for support as needed.
d. If student still presents continuing concerns at 6 weeks, contact the Brain Injury Resource Team.

11.8. TEACHERS
a. If teacher receives information from parent or student regarding a concussion, notify the health clerk so a student injury report can be completed.
b. Receives physician concussion guidance documentation information from district nurse or counselor.
c. Share observations and/or concerns for 3 consecutive weeks (if school is in session) with the counselor and district nurse.
d. Might be asked for continuing support beyond the 3-week monitoring period via physician concussion guidance documentation.

11.9. 504 COORDINATORS
a. Notified by the TBI Referral team that a student with a concussion needs more support per physician's concussion guidance documentation.
b. Convene problem-solving team to determine eligibility to 504 or Special Education.

12. APPENDIX

COMMUNICATION PLAN

Here is a list of action items, responsible person, and due dates for communicating the creation or revision of this document. All persons and/or functions affected by this document need to be briefed. The effective date of this procedure or procedure revision (shown at the top of the cover page) shall not be before the completion of the communication plan.

A. Brief Building Team Leaders. Assigned to Eric Schuette. Initial plan due by April 1, 2012. Done.
B. Brief counselors, health clerks, and nurses. Assigned to Chris McNiff. Initial plan due by April 1, 2012. Done. **Conduct annual training. Annually brief all staff at all schools.**
C. Brief school athletic directors, coaches. Assigned to Rob Berry. Initial plan due by April 1, 2012. Done. **Conduct annual training.**
D. E-mail notification to administrators, department heads, head secretaries, administrative assistants. Assigned to Ron Noriyuki. Due by April 1, 2012. Done.
E. **Implement induction plan for new employees.** Assigned to Lory Courtney. Due by July 1, 2012. Done.
F. E-mail notification of Revision B to administrators, department heads, head secretaries, administrative assistants. Assigned to Ron Noriyuki. Due by April 1, 2017.

13. REVISION RECORD

REV	CHANGE BY:		DESCRIPTION	CHK
NEW	Rob Berry Christine Mcniff Eric Schuette Belinda Strickland Lynn Wolfe Rick Ring Kahle Charles Renee Collier Lory Courtney Jacalyn Whittington	3-13-12	New	____
A	Rob Berry Christine Mcniff Eric Schuette Belinda Strickland Lynn Wolfe Jacalyn Whittington Rick Ring Lory Courtney	3-27-13	Clarified documentation and communication roles in sections 8.1, 9.1, 10, 10.1 and 11. Reformatted the first page of the St. Vrain Concussion Assessment tool and added trainer sign-off. Added the Concussion Letter to Teachers about Information Sheet and the TBI's Concussion Symptoms sheet. Removed both of the Brain Injuries / Concussions / Traumatic Brain Injuries (TBI) letters for teachers and parents and changed appropriate flow charts. Clarified flow charts and roles for non-school related concussions, including the physicians' role. Removed notation that teachers reference BrainSTARS. Removed the Head Injury Form and adjusted all references. Removed notification of district nurse if student is cleared to return to physical activity. Removed Student Injury Report form and referred to copy on district website.	____
B	Heather Keith Chris McNiff Bryan Krause Rob Berry Todd Jackson	3-20-17	Removed redundant notifications by the district nurse from flowcharts. In flowcharts, clarified handling of physician guidance documentation. Made other minor adjustments to reduce confusion and to reflect current practice, especially in Roles and Responsibilities. Under Roles and Responsibilities, added requirement that coaches complete annual concussion training. Deleted Concussion Letter to Teachers about Information Sheet. Added Student Referral Form.	____ BL ____

14. APPROVALS

Approvers shall be department heads or higher depending on the procedure's application.

The _B_ revision of document _614-1 Managing Concussions_ is approved by:

Bryan Krause, Student Serv. Exec. Dir.		3/21/17
Print Name, Title	Signature	Date

ST. VRAIN CONCUSSION ASSESSMENT TOOL

Combination of SCAT & SCAT2

Athlete Name:_____ **Date & Time of Injury:**_____

Primary Care or Follow-up Physician:_____ **This Tool Filled Out By:**_____

LOC or Unresponsiveness? Yes No Balance problems or unsteady? Yes No

Seizure or Convulsions? Yes No Other pertinent Hx:_____

Symptom Log

	Initial	30 Min.	1 Hour
Headache/ Head Pressure			
Blurred vision			
Diplopia			
Nystagmus			
Dizzy/ Off Balance			
Hearing problems			
Tinnitus			
"Don't feel right"			
Confusion			
Feeling "Dinged" or "Dazed"			
Feeling "Slowed down" or "In a fog"			
Drowsiness			
Fatigue or Weakness			
More Emotional Than Usual			
Irritable/Nervous/Anxious			
Difficulty Concentrating			
Amnesia			
Photophobia			
Sensitivity to Noise			
Other:_____			

Maddocks Score

	Correct	Incorrect
Venue?		
Which half?		
Who scored last?		
Team played last week?		
Win last game?		

Word Recall

Cite one column of words below and ask athlete to recall 3 times in any order. Place a mark next to each recalled word, each time (e.g., elbow: ✔ ✔ ✔) Start with left column and use other columns for repeat testing.

Elbow		Candle	
Apple		Paper	
Carpet		Sugar	
Saddle		Sandwich	
Bubble		Wagon	
Baby		Finger	
Monkey		Penny	
Perfume		Blanket	
Sunset		Stamp	
Iron		Sunset	

Reverse Digits & Months

Average success is 6 digits backward (2 tries) & all months. Circle successful recalls and "X" missed months.

5-2-8	3-9-1
6-2-9-4	4-3-7-1
8-3-2-7-9	1-4-9-3-6
7-3-9-1-4-2	5-1-8-4-6-8

Dec-Nov-Oct-Sep-Aug-Jul-Jun-May-Apr-Mar-Feb-Jan

Balance Testing

"Tandem Stance": Athlete stands heel-to-toe with non-dominant foot in back. Weight should be evenly distributed. Hands on hips and eyes closed. If you fall out of position open eyes and return to start position. Observe for 20 seconds & count errors which include lift hands off hips, eyes open, lift forefoot or heel, step stumble, or fall. >5 errors may suggest concussion.

Number of errors:

Delayed Word Recall

Should be able to recall 5 words from Word Recall Testing earlier.

Number of recalled words:

Neurological Exam

Speech:

Eye Motion & Pupils:

Gait:

Strength:

Sensory Exam:

DTRs:

Coordination (finger to nose):

Physician Clearance

☐ Athlete is symptom free and cleared to begin "Return to Play Progression"

Signature **Date**

☐ Athlete continues to exhibit post concussive symptoms and is NOT cleared at this time.

Date

*Physicians, information on the district concussion policies and the staged return to play can be found on the reverse side.

Athletes, Parents, and Physicians

ANY ABNORMALITY OR SYPMTOM NOTED DURING TESTING IS CONSIDERED INDICATIVE OF A CONCUSSION/HEAD INJURY. We suspect that your athlete has sustained a concussion. A concussion is defined as a trauma induced alteration in mental status. Concussion can be caused by a direct blow to the head or an indirect blow which causes the brain to "bounce" against the inside of the skull. Injury to the brain can present with a combination of any of a number of symptoms. Confusion and memory problems are the hallmark of concussion, but headache, nausea, vomiting, dizziness, ring in the ears, and visual disturbance are also common. Athletes that return to play too soon after a concussion have an increased incidence of complications. These complications include second impact syndrome (sudden brain swelling resulting in death), post-concussive syndrome (concussion symptoms persist after the concussion can be permanent), cumulative neurological dysfunction (problems with information processing and memory), and chronic traumatic brain injury. Your athlete should be monitored carefully. If any **RED FLAG** symptoms occur the athlete should be taken to the Emergency room.

What to Expect

- Most concussion resolve in 7-10 days, but recovery time may be longer in children and adolescents.
- All concussed athletes should rest from all physical and demanding mental activities, should not drive, and should not use alcohol, anti-inflammatory or sleeping medication until evaluated by a physician.
- All athletes with concussion require evaluation by their physician and signed clearance before they can begin the return to play progression.
- All signs and symptoms of concussion should be gone before an athlete returns to physical activity.

Red Flag Symptoms

- **Worsening Headache**
- **Repeated Vomiting**
- **Increased Drowsiness**
- **Difficulty Awakening**
- **Increased Confusion or Irritability**
- **Seizures**
- **Unequal Pupils**
- **Weakness or Numbness of the Arms or Legs**
- **Increased Unsteadiness**
- **Increasing Slurred Speech**
- **Worsening Vision**

Physicians

The long term health and wellness of the athlete is our number one priority. Numerous studies document the dangers and permanent effects associated with returning concussed athletes to participation before their symptoms subside. Below are bullet points of the St. Vrain Valley School District policies regarding head injuries.

Policies

- Athletes who display any symptoms of concussion are to be removed from participation.
- Athletes with ANY signs or symptoms of concussion should never be returned to play the day of re-injury independent of the brevity of symptoms.
- All athletes removed from play for concussion need to have signed clearance by a physician before they can begin the return to play progression.
- **Return to Play Decision Making is complex and is guided by a physician.** Considerations include: severity of current injury (symptoms and how long, complicating features?), previous head injuries (number, severity, proximity?), significant and/or prolonged injury with minor blow (are concussions occurring with less force and lasting longer?), age (maturing brain higher risk), sport risk, learning disabilities (brain reserve), past neuropsychological abnormalities, chronic post-concussive symptoms (e.g., headache, depression).
- Once the athlete has been cleared by a physician to play the athletic trainer will take the athlete through a staged return to play.
- If any athlete has persistent or recurring symptoms of concussion, he or she will be removed from all activity and instructed to contact his or her physician again.

Staged Return to Play Progression

1. Rest until asymptomatic
2. Light aerobic exercise
3. Sport-specific exercise
4. Non-contact training drills, light resistance training
5. Full contact training
6. Competition

The subsequent step should be 24 hours after the previous. If any stage causes symptoms to recur the athlete should return to stage one.

References and Resources

- CDC Traumatic Brain Injury Education: http://www.cdc.gov/ncipc/tbi/TBI.htm
- Dr. Madden (sports medicine, comprehensive concussion assessment, abbreviated neuropsychological testing): 303-772-5578
- Dr. Pavot (neurology): 303-485-3535
- Dr. John Kirk's (Comprehensive Neuropsychological Testing < 18 years) http://www.drjohnkirk.com/; 303-915-0108

St. Vrain Valley School District

395 South Pratt Parkway, Longmont, CO 80501 303.776.6200

REQUEST TO RELEASE OR SECURE CONFIDENTIAL INFORMATION

Date: _____

Student Name:_____DOB:_____

Address:_____

This is authorization for the following agencies to release and secure confidential information:

TO / FROM	**TO / FROM**
Agency Name: _____	Agency Name: _____
Agency Dept: _____	Agency Dept: _____
Contact Person:_____	Contact Person:_____
Address: _____	Address: _____
City:_____ State:_____	City:_____ State:_____
Zip:_____ Phone:_____	Zip:_____ Phone:_____
Fax:_____	Fax:_____
Email: _____	Email: _____

The following checked records will be released or secured:

☐ **Audiometric**	☐ **Educational**	☐ **Speech/Language**
☐ **Medical/Health**	☐ **Occupational Therapy**	☐ **Physical Therapy**
☐ **Psychiatric**	☐ **Psychological**	☐ **Social Work**

☐ **Other (Specify Below):**

All information released or secured will be in compliance with the Family Education Rights and Privacy and the Colorado Open Records Law. No additional information will be released or secured without prior approval from the parent/guardian, except as provided by law.

PARENTAL CONSENT

☐ **Yes** ☐ **No** **I consent to the transfer of information as stipulated above.**

_____

Signature of Parent/Guardian Date

Authorization for Disclosure of Protected Health Information

Patient Information

Patient Name _____ Birth date: _____
Last First MI
Phone_____ Parent/Guardian/Requester Completing Form:_____

Release To

I authorize (provider name and phone number):
_____
to Release Medical Record Information to:

Name
Address:
City/State/Zip:
Fax:

Purpose:

For the following purpose:

- ☐ Continuity of Care at school
- ☐ Insurance
- ☐ Legal
- ☐ Personal Use
- ☐ Other:_____

Information to Release

Doctor: _____ Hospital/Clinic: _____
Treatment Dates:
From (date):_____To (date):___

- ☐ Pertinent Information (Discharge Summary, H&P, X-Ray, Lab, Surgery, EKG, etc)
- ☐ Emergency Room/Urgent Care
- ☐ Immunization Record
- ☐ Clinic Information/Notes
- ☐ Lab Reports
- ☐ Discharge Summary
- ☐ Imaging Results
- ☐ Copy of Images
- ☐ Complete Medical Record (except _____)
- ☐ Communication with Providers
- ☐ Other _____

State/Federal Laws require specific authorization to release the following types of information. Please initial beside the types of information to be released:
____ HIV/AIDS Related ____ Genetic Testing ___ Drug/Alcohol abuse
____ Mental Health ____ Psychotherapy Notes ___ Sickle Cell Anemia

Delivery Instructions:

- ☐ Mail or fax records directly to person or organization specified
- ☐ Other_____

Patient/Authorized Representative Authorization

I understand that: (1) My signature on this form is strictly voluntary. (2) I may revoke this authorization at any time in writing, and if I do it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. (3) If the requester or receiver is not a health plan or health care provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations. (4) 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. (5) I may inspect or obtain a copy of the health information that I am being asked to disclose.
Expiration: Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 1year from the date hereof, unless otherwise specified: _____

_____ _____ _____
Signature Relationship to patient Date

Autorización para divulgar la información de salud protegida

Información del paciente

Nombre del paciente: Apellido Nombre Fecha de nacimiento:

Teléfono: Padre/Tutor/Solicitante que llena el formulario:

Extiéndase a

Autorizo a (nombre y teléfono de medico)
Dr. Abigail Collins
para que extienda la información de la historia clínica a:

Nombre:
Domicilio:
Teléfono: (303)772-7700 Fax: (303)651-3066

Finalidad:

Con la siguiente finalidad:

X Continuación del cuidado en escuela
☐ Seguro médico
☐ Legal
☐ Uso personal
☐ Otro:_____

Información por divulgar

Médico: Clínica/ Hospital:
Fechas del tratamiento:
De(fecha) _____ A(fecha)_____

☐ Info. pertinente (resumen del alta, anamnesis & exploración física, rayos-X, laboratorio, cirugía, EKG, etc.)
☐ Sala de urgencias/Atención de emergencia
☐ Cartilla de vacunación
☐ Información clínica/Anotaciones
☐ Dictámenes de laboratorio
☐ Resumen del alta
☐ Resultados de radiología
☐ Copia de las placas
☐ Historia clínica completa (excepto_____)
☐ Comunique con medico
☐ Otro _____

Las leyes estatales/federales requieren de una autorización específica para divulgar los siguientes tipos de información. Por favor, ponga sus iniciales junto al tipo de información que se divulgará:

_____ Relacionada con el VIH/SIDA _____ Pruebas genéticas
_____ Drogadicción./Alcoholismo _____ Salud mental
_____ Anotaciones de psicoterapia _____ Anemia drepanocítica

Instrucciones de entrega:

☐ Envíe los expedientes por correo o fax directamente a la persona o organización especificada.
☐ Otro_____

Autorización del Paciente/Represente autorizado

Comprendo que: (1) Mi firma en este formulario es completamente voluntaria. (2) Puedo revocar esta autorización en cualquier momento por escrito y, de hacerlo, no tendrá efecto alguno en cualquier acción que se haya tomado antes de recibir la revocación. Se pueden encontrar más detalles en el Aviso de prácticas de privacidad (Notice of Privacy Practices). (3) Si el solicitante o el destinatario no es un plan de salud o un proveedor de cuidado a la salud, el destinatario puede extender la información divulgada y puede ya no estar protegida por los reglamentos de privacidad federales. (4) Si no firmo este formulario, mi cuidado de salud, el pago de mi cuidado de salud o mi capacidad de inscripción para beneficios no se verán afectados. (5) Puedo revisar u obtener una copia de la información de salud que se me ha solicitado divulgar.

Vigencia: Sin manifestar mi revocación, este consentimiento caducará automáticamente una vez que se satisfaga la necesidad de la divulgación; en todo caso caducará dentro de 1 ano a partir de la fecha del presente documento, a menos que se indique lo contrario: _____.

_____

Firme Parentesco con el paciente Fecha

TBI's/CONCUSSIONS- Know the Symptoms Information Sheet

Here are some symptoms that are related to a student who is recovering from a concussion. Use these or any symptom that is unusual for the student. Every symptom is important. These are common symptoms clustered in general categories:

* One of the most important signs is not a specific symptom but a change in the student in one of the following areas. It's a change in the student that is usually the most noticeable.

Physical (How a person feels physically)	**Cognitive** (How a person thinks)
Headache/pressure Blurred vision Dizziness Poor balance Disorientation Ringing in ears Vacant stare/glassy eyed Nausea Vomiting Numbness/tingling Sensitivity to light Sensitivity to noise	Feeling in a "fog" Feel "slowed down" Difficulty remembering Difficulty concentrating/easily distracted Slowed speech Easily confused
Emotional (How a person feels emotionally)	**Maintenance** (How a person experiences energy and sleep)
Inappropriate emotions for a situation Nervousness/anxiety Lack of motivation Irritability Sadness Personality changes	Fatigue Excess sleep Trouble falling asleep Drowsiness Sleeping less than usual

ST. VRAIN VALLEY SCHOOLS
academic excellence by design

BRAIN INJURY RESOURCE TEAM

STUDENT REFERRAL FORM

REFERRING INFORMATION:

Date of Referral:
School Name:
Referring Staff Member:
Phone : Email :
Reason for Referral :

- Classroom Observation
- Intervention Ideas
- Evaluation/Special Ed Process
- Assistance with Plan for Re-Entry (if out of school)
- Other (please specify) :

PLAN FOR RE-ENTRY:

This could include: shortened schedule, extensive breaks, quiet place, schedule change, elimination of classes, reduced workload, etc.

DESCRIPTION OF INCIDENT:

Please describe the head injury to the best of your knowledge; please include date, place and activity as well as treatment:

NEEDS OF STUDENT:

END RESULT OF REFERRAL:

What questions would you like answered/addressed through this referral?

PLEASE PROVIDE THE FOLLOWING:

Please attach the following documentation if possible/applicable:

1. Permission for Referral (Parent Partnership Form)
2. Building Level Problem Solving Team Notes/Progress Monitoring
3. Current IEP or 504 Plan, including most current assessment information
4. Current School or Outside Agency Reports - Educational, Medical, PT/OT, Speech Language, Neurologist, Hospital, etc.
5. Any Current Plans - Individualized Health Plan, Safety Plan, Behavior Plan
6. Student Injury Report
7. Student's Current Schedule
8. SVVSD Symptom Checklist for Teachers/Staff

THANK YOU -

The District Brain Injury Resource Team meets on the first Wednesday of the month to review referrals or as needed. In the meantime, please refer to the BrainSTARS manual to assist in interventions and education for your building team. Please return this form and the additional supporting documentation to Emily Scott at Erie Elementary. Once your referral has been reviewed, you will receive an email with next steps.

Please check all symptoms observed in the classroom	**Additional Comments/Observations: Please document any additional information in this column**
Physical Symptoms: __Has a headache that gets worse when the student concentrates __Bothered by noises, specifically noisy hallways, lunchrooms, and assemblies __Has difficulty with bright or fluorescent lights __Nausea __Other (please note):	
Cognitive Symptoms: __Needs excessive time and repetition to learn a concept __Remembering information one time but forgetting it the next (Swiss cheese effect) __Needs multiple prompts to complete a task __Reduced processing speed (takes longer than it should to complete tasks) __Difficulty remembering previously learned information __Difficulty organizing or turning in assignments __Difficulty doing more than one thing at a time (such as listening and taking notes) __Other(please note):	
Emotional Symptoms: __Frequently irritable __Exhibits excessive nervousness/anxiety __Exhibits frequent mood changes __Easily overwhelmed during lectures or long assignments/assessments __Other(please note):	
Maintenance Symptoms: __Needs to take frequent breaks __Gets tired very easily, especially towards the end of the day __Loses track of time	
Of the symptoms marked above, which are most impactful in the classroom? What interventions/accommodations have been used to help the student in the classroom?	