MESA COUNTY PHYSICIANS IPA, INC.

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

Western Colorado Concussion Consortium
Final Teacher Feedback Form

PARENT: RETURN FORM TO HEALTHCARE PROVIDER TO BE CLEARED FOR RETURN TO ACTIVITY

Student Name: _____ Date: _____ School: _____

Date of Concussion: _____ Health Care Provider: _____

Your child has been diagnosed with a concussion and is being managed by your Healthcare Provider. It is **your** responsibility to gather signatures from his/her teachers before your child is cleared by his/her Healthcare Provider for return to physical activity. After it appears that your child has no concussion related symptoms, have your child contact their teachers and ask them to fill in the boxes below based upon your child's ***current*** performance in classes AND whether there is an ongoing need for academic adjustments in their classes (related to the current concussion). This process will allow your child's Healthcare Provider to make a decision whether or not it is safe to clear your child for return to physical activity.

Teachers: your feedback is very valuable in making decisions regarding return to physical activity. If you have noticed any physical, cognitive, and/or emotional symptoms in your classroom, please indicate below.

1 – Teacher name 2 – Class in which you teach this student	Is student receiving any academic adjustments in your class? If yes, please describe.	Have you noticed or has the student reported any concussion symptoms to you (e.g., headaches, dizziness, concentration or memory problems, irritability, fatigue etc.)? If yes, please explain.	To the best of your knowledge, is this student performing at their pre-concussion level?
			YES or NO Date: Teacher Signature:
			YES or NO Date: Teacher Signature:
			YES or NO Date: Teacher Signature:
			YES or NO Date: Teacher Signature:
			YES or NO Date: Teacher Signature:
			YES or NO Date: Teacher Signature:
			YES or NO Date: Teacher Signature:
			YES or NO Date: Teacher Signature:

School Counselor Signature: _____ Date: _____

(Please review important "disclaimer" information on reverse side of page)

For Patients / School Administrators / Parents:

DISCLAIMER: This form is provided to promote health as a public service and is merely informational. THIS DOES NOT CONSTITUTE MEDICAL ADVICE, and should not be used as a substitute for medical diagnosis or treatment by a medical professional. *If you suspect you or someone else may have suffered a concussion, consult a doctor immediately.* If there is an emergency, call 911. The Western Colorado Concussion Consortium and the Mesa County Physicians IPA ('Concussion Consortium') do not assume responsibility for the circumstances arising out of the use, misuse, interpretation, or application of this material to any situation. This information was intended to be accurate when created, but there is no obligation on the Concussion Consortium to update or correct these forms in the event that there are changes to the medical body of knowledge.

For Healthcare Providers:

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