Rocky Mountain Pediatric OrthoONE
Physician Care Health ONE

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Center4Concussion.com

TEACHER FEEDBACK FORM

Student Name:_____ **Date:**_____

School:_____ **Date of Concussion:**_____

Student, you have been diagnosed with a concussion and are being managed at the Center for Concussion. It is **your** responsibility to gather data from your teachers before you return to the Center for Concussion for a follow-up visit. A day or two before your next appointment, go around to all of your teachers (especially the CORE classes) and ask them to fill in the boxes below based upon how you are **currently** functioning in their class(es).

Teachers, Thank you for your help with this student. Your feedback is very valuable to us. We do not want to release this student back to physical activity if you are still seeing physical, cognitive, and emotional or sleep/energy symptoms in your classroom(s). If you have any concerns, please state them below! If you have questions or want to talk privately, please feel free to call the Center for Concussion.

1-Your name 2-Class in which you teach this student	**Is the student still receiving any academic adjustments in your class? If so, what?**	**Have you noticed, or has the student reported to you, any concussion symptoms lately? (e.g. complaints of headaches, dizziness, difficulty concentrating, remembering or seemed more irritable or fatigued than usual etc.?) If yes, please explain.**	**Do you believe that this student is performing at his/her pre-concussion learning level?**
			YES or NO Sign: Date:
			YES or NO Sign: Date:
			YES or NO Sign: Date:
			YES or NO Sign: Date:
			YES or NO Sign: Date:

COMMENTS: