BVSD Teacher Feedback Form - Concussion

Student Name: ______________________ Date: ______________________

Date of Concussion: ______________________ Concussion Team Leader: ______________________

Teachers: To ensure appropriate brain rest and opportunity for recovery, we are asking for feedback on any adjustments or symptoms continuing in your classroom(s). Information should be returned to the Concussion Team Leader.

Your Name and Class Taught	**Is the student still receiving any academic adjustments in your class? If so, what?**	**Have you noticed, or has the student reported, any continuing, new or worsening symptoms lately?** (e.g. complaints of headaches, dizziness, difficulty concentrating/ remembering, irritability, fatigue)	**Do you believe this student is performing at their pre-concussion learning level?**
Name: ____________ Class:	Yes, adjustments include: No	Yes No	Yes No Don't know Date: Signature:
Name: ____________ Class:	Yes, adjustments include: No	Yes No	Yes No Don't know Date: Signature:
Name: ____________ Class:	Yes, adjustments include: No	Yes No	Yes No Don't know Date: Signature:
Name: ____________ Class:	Yes, adjustments include: No	Yes No	Yes No Don't know Date: Signature:

This material is adapted from the Center for Concussion, Rocky Mountain Hospital for Children, REAP Manual

This form is to be completed initially 3 weeks post-concussion and will be used to assess the need for a formal 504 if symptoms are still present at that time.