Tool To Identify a Suspected Concussion

This tool is to be used as a quick reference in helping to identify a suspected concussion. In all cases of a suspected concussion, the student must be examined by a medical doctor or nurse practitioner for diagnosis and must follow Concussion Management Procedures – Return to Learn/Return to Physical Activity. Following a blow to the head, neck or face or a blow to the body that transmits force to the head, a concussion must be suspected in the presence of **any one or more** of the signs or symptoms outlined in the chart below and/or the failure of the Quick Memory Function Assessment.

An incident occurred involving (student/athlete name) _____ (date) _____Feb. 9th/2016 Time: 11:00 a.m.

He/she was observed for signs and symptoms of a concussion: (CHECK APPROPRIATE BOX)

❑ No signs or symptoms described below were noted at the time. **Note: Continued monitoring of the student is important as signs and symptoms of a concussion may appear hours or days later.**

❑ The following signs were observed and/or symptoms reported:

Signs and Symptoms of Suspected Concussion	
Possible Signs Observed (CHECK APPROPRIATE BOX) *A sign is something that will be observed by another person (e.g., parent/guardian, teacher, coach, supervisor, peer).*	**Possible Symptoms Reported (CHECK APPROPRIATE BOX)** *A symptom is something the student will feel/report.*
Physical ❑ vomiting ❑ slurred speech ❑ slowed reaction time ❑ poor coordination or balance ❑ blank stare/glassy-eyed/dazed or vacant look ❑ decreased playing ability ❑ loss of consciousness or lack of responsiveness ❑ lying motionless on the ground or slow to get up ❑ amnesia ❑ seizure or convulsion ❑x grabbing or clutching of head **Cognitive** ❑ difficulty concentrating ❑ easily distracted ❑ general confusion ❑ cannot remember things that happened before and after the injury *(see Quick Memory Function Assessment)* ❑ does not know time, date, place, class, type of activity in which he/she was participating ❑ slowed reaction time (e.g., answering questions or following directions) **Emotional/Behavioural** ❑ strange or inappropriate emotions (e.g., laughing, crying, getting angry easily) **Sleep Disturbance** ❑ Drowsiness (‘a little bit.”) ❑ Insomnia	**Physical** ❑ headache ❑ pressure in head ❑ neck pain ❑ feeling off/not right ❑ ringing in the ears ❑ seeing double or blurry/loss of vision ❑ seeing stars, flashing lights ❑ pain at physical site of injury ❑ nausea/stomach ache/pain ❑ balance problems or dizziness ❑ fatigue or feeling tired ❑ sensitivity to light or noise **Cognitive** ❑ difficulty concentrating or remembering ❑ slowed down, fatigue or low energy ❑ dazed or in a fog **Emotional/Behavioural** ❑ irritable, sad, more emotional than usual ❑ nervous, anxious, depressed ❑ other **Sleep Disturbance** ❑ Drowsiness ❑ Insomnia ❑ other signs and/or symptoms:
If any observed signs or symptoms worsen, call 911.	

Appendix A – Tool To Identify A Suspected Concussion

Quick Memory Function Assessment - Failure to answer any of these questions correctly may indicate a concussion:

What room are we in right now? *Answer* _____

What activity/sport/game are we playing now? *Answer* _____

What field are we playing on today? *Answer* _____

What part of the day is it? *Answer* _____

What is the name of your teacher/coach? *Answer* _____

What school do you go to? *Answer* _____

Actions to beTaken:
If there are any signs observed or symptoms reported, or if the student fails to answer any of the above questions correctly, concussion should be suspected and the student must be immediately removed from play and must not be allowed to return to play that day even if the student states that he/she is feeling better. Students with a suspected concussion should not be left alone and must not leave the premises without parent/guardian (or emergency contact) supervision.

Continued Monitoring by Parent/Guardian:
Students should be monitored following the incident as signs and symptoms can appear immediately after the injury or may take hours or days to emerge. If any signs or symptoms emerge, the student needs to be examined by a medical doctor or nurse practitioner as soon as possible that day.

Principal/Coach/Teacher Name: _____

Signature: _____ **Date:** _____ **Time:** _____

****This form must be copied, with the original filed in the Student's OSR and the copy provided to parent/guardian****

Concussion Passport for BHNCDSB

_____ (student name) sustained a suspected concussion on _____ (date) at _____ (time). As a result, this student must be seen by a medical doctor or nurse practitioner. Prior to returning to school, the parent/guardian must inform the school Principal of the results of the medical examination by completing the following:

Results of Medical Examination

- ❑ My child/ward has been examined and **no concussion** has been diagnosed and therefore may resume full participation in learning and physical activity with no restrictions.
- ❑ My child/ward has been examined and **a concussion has been diagnosed** and therefore must begin a medically-supervised, individualized and gradual Return to Learn/Return to Physical Activity Plan.
- ❑ I have been informed of the school's concern regarding my child having a suspected concussion and decline to have him/her assessed by a medical professional.

Parent/Guardian signature: _____ **Date:** _____

Physician signature: _____ **Date:** _____

Comments:

_____

_____

_____

_____

_____

Reproduced and adapted with permission from OPHEA, *Ontario Physical Education Safety Guidelines, Appendix C-3 – Documentation of Medical Examination, 2013.*

Documentation for a Diagnosed Concussion

The Return to Learn/Return to Physical Activity Plan is a combined approach. Step 2a – Return to Learn must be completed prior to the student returning to physical activity. Each step must take a <u>minimum of 24 hours</u> (Note: Step 2b – Return to Learn and Step 2 – Return to Physical Activity occur concurrently).

<u>Step 1 – Return to Learn/Return to Physical Activity</u>

- Completed at home.
- Cognitive Rest – includes limiting activities that require concentration and attention (e.g., reading, texting, television, computer, video/electronic games).
- Physical Rest – includes restricting recreational/leisure and competitive physical activities.

❑ My child/ward has completed Step 1 of the Return to Learn/Return to Physical Activity Plan (cognitive and physical rest at home) and his/her **symptoms have shown improvement**. My child/ward will proceed to Step 2a – Return to Learn.

❑ My child/ward has completed Step 1 of the Return to Learn/Return to Physical Activity Plan (cognitive and physical rest at home) and is **symptom free**. My child/ward will proceed directly to Step 2b – Return to Learn and Step 2 – Return to Physical Activity.

Parent/Guardian signature: _____ **Date:** _____
Comments:
_____
_____
_____

If at any time during the following steps symptoms return, please refer to the "Return of Symptoms" section on page 2 of this form.

<u>Step 2a – Return to Learn</u>

- Student makes gradual return to instructional day.
- Requires individualized classroom strategies and/or approaches which gradually increase cognitive activity.
- Physical rest – includes restricting recreational/leisure and competitive physical activities.

❑ My child/ward has made a gradual return to his/her instructional day and has been receiving individualized classroom strategies and/or approaches and is **symptom free**. My child/ward will proceed to Step 2b – Return to Learn and Step 2 – Return to Physical Activity.

Parent/Guardian signature: _____ **Date:** _____
Comments:
_____
_____
_____
_____

Step 2b – Return to Learn

- Student returns to regular learning activities at school.

Step 2 – Return to Physical Activity

- Student can participate in individual light aerobic physical activity only.
- Student continues with regular learning activities.

❑ My child/ward is symptom free after participating in light aerobic physical activity. My child/ward will proceed to Step 3 – Return to Physical Activity.

❑ **Appendix C will be returned to the teacher to record progress through Steps 3 and 4**

Parent/Guardian signature: _____ **Date:** _____

Comments:

_____
_____
_____

Step 3 – Return to Physical Activity

- Student may begin individual sport-specific physical activity only.

Step 4 – Return to Physical Activity

- Student may begin activities where there is no body contact (e.g., dance, badminton); light resistance/weight training; non-contact practice; and non-contact sport-specific drills.

❑ **Student has successfully completed Steps 3 and 4 and is symptom free.**

Comments:

_____
_____
_____

❑ **Appendix C will be returned to parent/guardian to obtain medical doctor/nurse practitioner diagnosis and signature.**

Teacher signature: _____ **Date:** _____

Medical Examination:

❑ I, _____(medical doctor/nurse practitioner name) have examined (_____) and confirm he/she continues to be symptom free and is able to return to regular physical education class/intramural activities/interschool activities in non-contact sports and full training/practices for contact sports.

Medical Doctor/Nurse Practitioner Signature: _____ **Date:** _____

Comments:

_____
_____
_____

Step 5 – Return to Physical Activity

Student may resume regular physical education/intramural activities/interschool activities in non-contact sports and full training/practices for contact sports.

Step 6 – Return to Physical Activity

Student may resume full participation in contact sports with no restrictions.

Return of Symptoms

❑ My child/ward has experienced a return of concussion signs and/or symptoms and has been examined by a medical doctor/nurse practitioner, who has advised a return to:

Step _____ of the Return to Learn/Return to Physical Activity Plan

Parent/Guardian signature: _____ **Date:** _____

Physician signature: _____ **Date:** _____

Comments:

_____
_____
_____

Reproduced and adapted with permission from *OPHEA, Ontario Physical Education Safety Guidelines, Appendix C-4 Documentation for a Diagnosed Concussion – Return to Learn/Return to Physical Activity Plan, 2013*.

INFORMED CONSENT / PERMISSION FORM FOR SCHOOL TEAMS

_____ is arranging _____ on _____
[Name of School] *[Description of activity]* *[Date (s)]*

THIS FORM MUST BE READ AND SIGNED BY EVERY STUDENT WHO WISHES TO PARTICIPATE AND BY A PARENT GUARDIAN OF A PARTICIPATING STUDENT IF THE STUDENT IS UNDER 18 YEARS OF AGE.

ELEMENTS OF RISK:
School activities involve certain elements of risk. Injuries may occur while participating in these activities. The following includes, but is not limited to, examples of the types of injury which may result during an activity: fracture, laceration, sprain, strain, contusion, concussion, etc.

The risk of sustaining these types of injuries result from the nature of the activity and can occur without any fault of either the student, or the school board, its employees/agents or the facility where the activity is taking place. By choosing to take part in this activity, you are accepting the risk that you/your student may be injured.

The chance of injury occurring can be reduced by carefully following instructions at all times while engaged in the activity.

If you choose to participate, you must understand that you bear the responsibility for any injury that might occur.

Please indicate if your student has been diagnosed as having any medical conditions and provide pertinent details.

If your student is presently diagnosed with a concussion by a medical doctor/nurse practitioner, that was sustained outside of school physical activity, the Concussion Passport must be completed before the student returns to physical education classes, Daily Physical Activity (DPA), intramural activities and interschool practices and competitions. Request the form from the school administrator.

The **Brant Haldimand Norfolk Catholic District School Board** does not provide accidental death, disability, dismemberment or medical expense insurance on behalf of the students participating in this activity. As per school board policy, **all students** participating in extra-curricular athletic activities **MUST** have **Student Accident Insurance** made available by the school to parents at the beginning of the school year **or have private coverage** in effect. Student accident insurance is available all year, not just at the beginning of the school year. Parents can go to www.insuremykids.com to purchase the insurance.

ACKNOWLEDGEMENT
WE HAVE READ THE ABOVE. WE UNDERSTAND THAT IN PARTICIPATING IN THE ACTIVITY DESCRIBED ABOVE, WE ARE ASSUMING THE RISKS ASSOCIATED WITH DOING SO.

Signature of Student: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____
(if student under 18 years of age)

PERMISSION

I give _____ permission to participate in the activity described above.
(Name of Student)

Signature of Parent/Guardian _____ **Date:** _____
(or student if over 18 years of age)

Student Concussion Diagnosis Report

School: _____

Principal: _____

Student(s) Name(s) Surname: Given Name:	Date of Birth YYYY/Month/Day	Return to Learn/Return to Physical Activity Plan in Place	Return to Learn/Return to Physical Activity Plan Completed (Y) Ongoing (N)
1.		❑ YES	❑ YES ❑ NO
Date/Location of incident:	**Circumstances causing concussion:**		
2.		❑ YES	❑ YES ❑ NO
Date/Location of incident:	**Circumstances causing concussion:**		
3.		❑ YES	❑ YES ❑ NO
Date/Location of incident:	**Circumstances causing concussion:**		
4.		❑ YES	❑ YES ❑ NO
Date/Location of incident:	**Circumstances causing concussion:**		
5.		❑ YES	❑ YES ❑ NO
Date/Location of incident:	**Circumstances causing concussion:**		
6.		❑ YES	❑ YES ❑ NO
Date/Location of incident:	**Circumstances causing concussion:**		

BRANT HALDIMAND NORFOLK CATHOLIC DISTRICT SCHOOL BOARD **Student Concussion Diagnosis Report**

❑January 30 ❑June 28

Submit completed form promptly to your Superintendent of Education