Pembina Hills
PUBLIC SCHOOLS

# Documentation of Concussion Monitoring/ Medical Examination Form

F 6-08C

**This Concussion Recognition Tool is a quick reference to help identify a suspected concussion and to communicate this information to the parent/guardian/emergency contact.**

An incident occurred involving _____ (student/ name) on_____ (date). He/ she was observed for signs and symptoms of a concussion (a blow to the head, face or neck or a blow to the body that transmits a force to the head).

| ☐ No signs or symptoms described below were noted at the time. | ☐ The following signs were observed or symptoms reported (complete signs and symptoms of suspected concussion chart) |
|---|---|
| Signs or symptoms can occur later within a 24-hour period. Your child/ward is not to participate in physical activity for a 24-hour period. While at home the parent/guardian is to monitor their child/ward using the information found in the Concussion Guidelines for Parents and Parents Guide to Dealing with Concussions documents provided. School staff will monitor the student/athlete while at school. | |
| **ACTIONS:** | **ACTIONS:** |
| If no signs/symptoms occur during the monitoring period, the parent/guardian is to complete the following **Results of Monitoring** section prior to their child/ward returning to school. | If there are **any** signs observed or symptoms reported, or if the student/ athlete fails to answer any of the above questions correctly:<br>• A concussion should be suspected;<br>• The student must be removed from play and not be allowed to return to play that day even if the student states that he/she is feeling better; and<br>• The student must not leave the premises without parent/ guardian/ emergency contact supervision.<br>• In **ALL** cases of a suspected concussion, the participant must be examined by a medical doctor for diagnosis. |

**Results of Monitoring**

☐ As the parent/guardian, my child/ward has been observed for the 24-hour period, and no signs/symptoms have been observed.

Parent/Guardian signature: _____Date: _____

Comments: _____


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| Signs and Symptoms of Suspected Concussion | |
|---|---|
| **Possible Signs Observed:**<br>A sign is something that is observed by another person (i.e.) parent, staff member, peer | **Possible Symptoms Reported:**<br>A symptom is something the student will feel/ report |
| **Physical:**<br>☐ Vomiting<br>☐ Slurred speech<br>☐ Slowed reaction time<br>☐ Poor coordination or balance<br>☐ Blank stare/glassy eyed/ dazed or vacant look<br>☐ Decreased playing ability<br>☐ Loss of consciousness or lack of responsiveness<br>☐ Lying motionless on the ground or slow to get up<br>☐ Amnesia<br>☐ Seizure or convulsion<br>☐ Grabbing or clutching of the head | **Physical:**<br>☐ Headache<br>☐ Pressure in head<br>☐ Neck pain<br>☐ Feeling off/ not right<br>☐ Ringing in the ears<br>☐ Seeing double or blurry/ loss of vision<br>☐ Seeing stars, flashing lights<br>☐ Pain at physical site of injury<br>☐ Nausea/ stomach ache/ pain<br>☐ Balance problems or dizziness<br>☐ Fatigue or feeling tired<br>☐ Sensitivity to light or noise |
| **Cognitive:**<br>☐ Difficulty concentrating<br>☐ Easily distracted<br>☐ General confusion<br>☐ Cannot remember things that happened before and after the injury (see quick memory function assessment below)<br>☐ Does not know the time, date, place, class<br>☐ Slowed reaction time (ie) answering questions, following directions | **Cognitive:**<br>☐ Difficulty concentrating or remembering<br>☐ Slowed down, fatigue or low energy<br>☐ Dazed or in a fog |
| **Emotional/ Behavioural:**<br>☐ Strange or inappropriate emotions (ie) laughing, crying, getting angry | **Emotional/ Behavioural:**<br>☐ Irritable, sad, nervous, anxious<br>☐ Other |
| **Quick Memory Function Assessment**<br>Failure to answer any of these questions correctly may suggest a concussion:<br>1. Where are we right now? _____<br>2. What activity/ sport/ game are we playing? _____<br>3. What is the name of your teacher/ coach? _____<br>What school do you go to? | |

**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 understand that the school has a documentation process for this plan.

Parent/Guardian signature: _____ Date: _____

Comments: _____



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