Appendix I: Student Concussion Diagnosis Report

TO BE COMPLETED BY THE SCHOOL PRINCIPAL

NIAGARA CATHOLIC DISTRICT SCHOOL BOARD

Student Concussion Diagnosis Report

School:	Principal:

Student(s) Name(s) Surname Given Name	Date of Birth YYYY/MM/DD	Documentation for a Diagnosed Concussion - Return to School/Return to Physical Activity Plan in Place	Status of Return to School/ Return to Physical Activity Plan Completed(Y) Ongoing (N)
1.		YES NO	YES NO
Date/Location of incident:	**Circumstances causing concussion:**		
2.		YES NO	YES NO
Date/Location of incident:	**Circumstances causing concussion:**		
3.		YES NO	YES NO
Date/Location of incident:	**Circumstances causing concussion:**		
4.		YES NO	YES NO
Date/Location of incident:	**Circumstances causing concussion:**		
5.		YES NO	YES NO
Date/Location of incident:	**Circumstances causing concussion:**		

Annual Concussion Awareness Training (to be completed by the Last Wednesday in September in honour of Rowan's Law day.
Staff Completed on: DATE
Comments: