Appendix D2: Documentation of Monitoring/Medical Assessment Form

This form is provided to the parent/guardian, in conjunction with
Appendix C1 - Tool to Identify a Suspected Concussion

MONITORING FORM

Student name _____ Date _____ sustained a significant impact to the head, face or neck or elsewhere on the body (observed or reported), and the individual responsible for that student suspects a concussion.

Results of initial assessment using Tool to Identify a Suspected Concussion:

☐ **NO SIGNS OR SYMPTOMS OBSERVED AT TIME OF INCIDENT.**
Signs or symptoms can occur later within a 24-hour period. Your child is **not** to participate in physical activity for a **24-hour period**. While at home parent/guardian is to monitor their child using the ***Tool to Identify a Suspected Concussion*** **(Appendix C1**). School Staff will monitor the student/athlete while at school.

Actions: If no signs/symptoms occur during the monitoring period, parent/guardian is to complete the Results of Monitoring section and submit the *Documentation of Monitoring/Documentation of Medical Assessment* (Appendix D2) to the principal after the monitoring period is completed.

Results of Monitoring

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

Parent/Guardian Signature: _____ ***Date:*** _____

***Comments*:**

_____

_____

_____

If signs or symptoms are observed within the 24-hour monitoring period, please fill out the Medical Assessment Form to follow.

MEDICAL ASSESSMENT FORM

Student Name: _____ ***Date:*** _____

Your child must be seen by a medical doctor or nurse practitioner as soon as possible with the results of Medical Examination form (to follow) returned to the school principal after medical assessment.

☐ **SIGNS OR SYMPTOMS were observed or reported by the individual responsible your child**

Results of Medical Assessment (to be completed by the Parent/Guardian)

☐ My child has been examined and **a concussion has not** been diagnosed and therefore may resume full participation in learning and physical activity with no restrictions.

☐ My child has been assessed and a concussion has not been diagnosed but the assessment led to the following diagnosis and recommendations:

_____

_____

☐ My child has been examined and **a concussion has been diagnosed** and therefore must begin a medically supervised, individualized and gradual Return to School (RTS) and Return to Physical Activity (RTPA) Plan (**Appendix E1 and E2**)

Medical Doctor/Nurse Practitioner providing assessment

Name: _____

Phone Number: _____

Parent/Guardian

Parent/Guardian Signature: _____ ***Date:*** _____

***Comments*:**

_____

_____

_____

The information provided on this form is collected pursuant to the Board's education responsibilities as set out in the Education Act and its regulations. This information is protected under the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA) and will be utilized only for the purpose of managing student learning and well-being. Access to this information will be limited to those who have an administrative need, to the student to whom the information relates and the parent(s)/guardian (s) of a student who is under 18 years of age. Any questions with respect to this information should be directed to the school principal.