NIAGARA CATHOLIC
DISTRICT SCHOOL BOARD

TOOL TO IDENTIFY A SUSPECTED CONCUSSION FORM

This form is to be completed by school staff to identify signs and symptoms of a suspected concussion, observed or reported. The completed form along with the Concussion Monitoring and Medical Assessment Forms are to be shared with the student and parents/guardians of a student under 18 years of age to communicate the follow-up requirements.

Student Name:			**Date:** mm/dd/year	
Time of Incident:		☐ A.M. ☐ P.M.	**Completed by**:	

STEP 1: Check for Red Flags

If one or more of the following **Red Flag** signs/symptoms are identified, **CALL 911** immediately. Then contact parents/guardians/emergency contact.

☐ Loss of consciousness or responsiveness
☐ Visible deforming of the skull
☐ Repeated vomiting
☐ Seizure or convulsion
☐ Loss of vision or double vision
☐ Weakness or numbness/tingling/burning in arms or legs
☐ Neck pain or tenderness
☐ Severe or increasing headache
☐ Increased confusion or deteriorating conscious state (becoming less responsive, drowsy)
☐ Increasingly restless, agitated, or combative

CONFIRMATION OF ACTIONS:
☐ EMS contacted
☐ Parents/Guardians or emergency contact notified
☐ Copy of the form provided to parents/guardians or emergency contact
☐ Principal notified and original form submitted to the principal
☐ OSBIE Report completed

Comments:
_____
_____
_____

Signature:_____ ***Date*** _____

STEP 2: When **Red Flags** have not been observed, complete the following prior to contacting the parents/guardians/emergency contact.

Student Name:			**Date:** mm/dd/year	
Time of Incident:		☐ A.M. ☐ P.M.	**Completed by**:	

VISUAL CLUES:

☐ Lying motionless on the playing surface (no loss of consciousness)
☐ Slow to get up after a direct or indirect hit to the head
☐ Disorientation or confusion, or an inability to respond appropriately to questions
☐ Dazed, blank or vacant look
☐ Unsteady on feet/balance problems or falling over/poor coordination/wobbly
☐ Facial injury
☐ Vomiting

PHYSICAL SYMPTONS: Ask student if they are experiencing any of the following:

☐ Balance problems	☐ Sensitivity to noise
☐ Blurred vision	☐ More emotional
☐ Dizziness	☐ Sadness
☐ Drowsiness	☐ Nervous or anxious
☐ Fatigue or low energy	☐ Difficulty concentrating or remembering
☐ Headache	☐ Feeling like “in a fog”
☐ Sensitivity to light	☐ Pressure in Head

Orientation/awareness questions (record student responses)

Primary/Junior Questions	**Student Responses**
1. What is your name?	
2. How old are you?	
3. What grade are you in?	
4. What is your teacher’s name?	

Intermediate/Senior Questions	**Student Responses**
1. Where do you go to school?	
2. What part of the day is it?	
3. What activity/sport/game are we playing now?	
4. What is the name of your teacher/coach?	

CONFIRMATION OF ACTIONS:

☐ Parents/Guardians or emergency contact notified
☐ Copy of the form provided to parents/guardians or emergency contact
☐ Principal notified and original form submitted to the principal
☐ OSBIE Report completed

Signature:_____ ***Date*** _____

NIAGARA CATHOLIC
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Concussion Monitoring and Medical Assessment Forms

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.

These forms are to be provided to the student, or the parents/guardians of a student who is under 18 years of age who is suspected of having sustained a concussion.

INCIDENT REPORT

On, _____, _____, sustained a significant
Date **Name of Student**
impact to the head, face, neck or elsewhere on the body (observed or reported), and I, _____

_____ suspect that the student may have sustained a concussion.
Name of Individual, and Role,

Using the OPHEA Tools to Identify a Suspected Concussion the following action must be taken:

☐ **NO SIGNS OR SYMPTONS WERE OBSERVED AT THE TIME OF THE INCIDENT**
If no signs and symptoms have been reported the parents/guardians must monitor their child for 48 hours and complete, sign and submit the Concussion Monitoring Form below. The form must be submitted to the school principal.

- the student may continue to attend school and participate in learning only.
- after 24 hours, and no signs or systems are observed the student may participate in physical activities.

☐ **YES, SIGNS OR SYMPTONS WERE OBSERVED AT THE TIME OF THE INCIDENT**
If signs and symptoms have been reported, the parents/guardians must have the student assessed by a physician/nurse practitioner as soon as possible. The physician/nurse practitioner will be required complete and sign the Concussion Medical Assessment Form below. The form must be submitted to the school principal prior to the student returning to school.

PARENTS/GUARDIANS CONCUSSION MONITORING FORM

Parents/Guardians Concussion Monitoring

☐ I confirm that my child has been observed for 48 hours, and that no signs or symptoms of a concussion have been observed.

☐ I confirm that my child may fully participate in physical activities.

☐ I confirm that I will immediately notify the school principal if my child experiences any signs or symptoms of a concussion.

Signature of Parents/Guardians: ***Date:***

Comments:

_____

_____

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CONCUSSION MEDICAL ASSESSMENT FORM

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.

This form must be completed and signed by a physician/nurse practitioner.

On, _____, _____, sustained a significant
Date **Name of Student**
impact to the head, face, neck or elsewhere on the body (observed or reported), and I, _____

_____ suspect that the student may have sustained a concussion.
Name of Individual, and Role,

Using the OPHEA Tools to Identify a Suspected Concussion:

☐ **YES, SIGNS OR SYMPTONS WERE OBSERVED AT THE TIME OF THE INCIDENT**
If signs and symptoms have been reported, the parents/guardians must be assessed by a physician/ nurse practitioner as soon as possible. The physician/nurse practitioner will be required complete and sign the Concussion Medical Assessment Form below. The form must be submitted to the school principal prior to the student returning to school.

RESULTS OF THE CONCUSSION MEDICAL ASSESSMENT

☐ My child has been assessed and a concussion ***has not*** been diagnosed and therefore may resume full participation in learning and physical activity without any restrictions.

☐ My child has been assessed and a concussion ***has*** been diagnosed and therefore, must being a medically supervised, individualized and gradual Return to School Plan-Return to Learn and Return to Physical Activity.

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

Comments:
_____
_____
_____

Physician/Nurse Practitioner:
Name: **Contact Number**:

Signature: _____

Signature of Parents/Guardians: _____

Date: _____