



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 SYMPTOMS: 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 _____



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 SYMPTOMS 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: _____