# Appendix C – Tool to Identify a Suspected Concussion

**This tool is a quick reference, to be completed to help identify a suspected concussion and to communicate this information to parent/guardian.**

## Identification of Suspected Concussion – 3 Step Process

Following a blow to the head, face or neck, or a blow to the body that transmits a force to the head, a concussion must be suspected in the presence of **any one or more** of the signs or symptoms outlined in the chart below **and/or** the failure of the Quick Memory Function Assessment.

## Step 1: Check appropriate box

An incident occurred involving _____ (student name) on _____ (date) at _____ (time).

He/she was observed for signs and symptoms of a concussion.

☐ No signs or symptoms described below were noted at the time of assessing the student/athlete.
***Note:** Continued monitoring of the student/athlete is important as signs and symptoms of a concussion may appear hours or days later (refer to #3 b) on the reverse).*

☐ The following signs were observed or symptoms reported:

**Physical**
- ☐ vomiting
- ☐ slurred speech
- ☐ slowed reaction time
- ☐ poor coordination or balance
- ☐ blank stare/glassy-eyed/dazed or vacant look
- ☐ decreased playing ability
- ☐ loss of consciousness or lack of responsiveness
- ☐ lying motionless on the ground or slow to get up
- ☐ amnesia
- ☐ seizure or convulsion
- ☐ grabbing or clutching of head

**Cognitive**
- ☐ difficulty concentrating
- ☐ easily distracted
- ☐ general confusion
- ☐ cannot remember things that happened before and after the injury *(see Quick Memory Function Assessment)*
- ☐ does not know time, date, place, class, type of activity in which he/she was participating
- ☐ slowed reaction time (e.g., answering questions or following directions)

**Emotional/Behavioural**
- ☐ strange or inappropriate emotions (e.g., laughing, crying, getting angry easily)
- ☐ other _

**Sleep Disturbance**
- drowsiness
- insomnia

**Physical**
- ☐ headache
- ☐ pressure in head
- ☐ neck pain
- ☐ feeling off/not right
- ☐ ringing in the ears
- ☐ seeing double or blurry/loss of vision
- ☐ seeing stars, flashing lights
- ☐ pain at physical site of injury
- ☐ nausea/stomach ache/pain
- ☐ balance problems or dizziness
- ☐ fatigue or feeling tired
- ☐ sensitivity to light or noise

**Cognitive**
- ☐ difficulty concentrating or remembering
- ☐ slowed down, fatigue or low energy
- ☐ dazed or in a fog

**Emotional/Behavioural**
- ☐ irritable, sad, more emotional than usual
- ☐ nervous, anxious, depressed
- ☐ other

Sleep disturbance
- Drowsy
- Sleeping more/less than usual
- Difficulty falling asleep

PLEASE TURN OVER

**If any observed signs or symptoms worsen, call 911.**

## Step 2: Perform Quick Memory Function Assessment

Ask the student/athlete the following questions, recording the answers below. Failure to answer any one of these questions correctly may indicate a concussion:

- What room are we in right now? *Answer*: _____
- What activity/sport/game are we playing now? *Answer*: _____
- What field are we playing on today? *Answer*: _____
- What part of the day is it? *Answer*: _____
- What is the name of your teacher/coach? *Answer*: _____
- What school do you go to? *Answer*: _____

## Step 3: Action to be taken

☐ **Signs observed or Symptoms reported:**

If there are **any** signs observed or symptoms reported, or if the student/athlete fails to answer any of the above questions correctly:

- a concussion should be suspected;
- the student/athlete must be immediately removed from play and must not be allowed to return to play that day even if the student/athlete states that he/she is feeling better; and
- the student/athlete must not leave the premises without parent/guardian (or emergency contact) supervision.

In all cases of a suspected concussion, the student/athlete must be examined by a medical doctor or nurse practitioner for diagnosis and must follow the Student Concussion and Head Injury Policy.

☐ **No signs observed or symptoms reported:**

- Mandatory precautionary withdrawal of student from physical activity.
- Student/Athlete to be monitored for a minimum of 24 - 48 hours following the incident as signs and symptoms can appear immediately after the injury **or may take hours or days to emerge.** Monitoring of the student/athlete to take place at home by parents and at school by school staff. To monitor for signs and symptoms parents/guardians can use the chart on the front of this information form.
- If any signs or symptoms emerge, the student/athlete needs to be examined by a medical doctor or nurse practitioner as soon as possible that day.

***School Contact/Teacher Advisor Name:*** _____ ***Date:*** _____

Following the completion of this form (Appendix C), an OSBIE Incident Report form must be completed, indicating that the tool has been completed and the parent/guardian has received copies of Appendix C and Appendix D2.

Under the direction of the *Ontario Ministry of Education* and under the legal authority of the *Education Act*, Grand Erie District School Board collects this information in order to fulfil its commitment to promote the health and safety of students by raising awareness, identification, and prevention of concussion injuries, and managing diagnosed concussions. In accordance with the *Municipal Freedom of Information and Protection of Privacy Act* this information will be used solely to assess the student's Return to Learn and Return to Physical Activity. It will be retained in the Ontario Student Record [OSR] for one year after the student graduates or transfers out of the school. The Ministry of Education may also request school reports on concussion activity. If you have any questions or concerns about the collection of information on this form please contact the school principal.

*The original copy is filed with the principal

**Duplicate copy provided to parent/guardian

# Appendix D2 – Documentation of Monitoring/Medical Examination Form

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

_____ (student name) _____(date), sustained a blow to the head, face or neck or a blow to the body that transmits a force to the head, and as a result may have suffered a concussion.

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

☐ **NO SIGNS OR SYMPTOMS OBSERVED AT TIME OF INCIDENT.**
However, 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 parent/guardian is to monitor their child/ward using the ***Tool to Identify a Suspected Concussion*** **(Appendix C)**. 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 following Results of Monitoring section and submit the *Documentation of Monitoring/Documentation of Medical Examination* (Appendix D2) to the principal after the monitoring period is completed.

**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:*** _____

_____

☐ **SIGNS OR SYMPTOMS OBSERVED:** _____ **AT TIME OF INCIDENT**

_____ **DURING THE 24 HOUR MONITORING PERIOD**

For the signs and/or symptoms observed at the time of incident/during the 24 hour monitoring period, refer to the ***Tool to Identify a Suspected Concussion*** **(Appendix C)** provided by teacher/coach/supervisor.

**Actions:** Your child/ward 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 examination.

## 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.

***Parent/Guardian signature:*** _____

***Date:*** _____

***Comments:*** _____

_____



**Original filed in OSR.**

Under the direction of the *Ontario Ministry of Education* and under the legal authority of the *Education Act*, Grand Erie District School Board collects this information in order to fulfil its commitment to promote the health and safety of students by raising awareness, identification, and prevention of concussion injuries, and managing diagnosed concussions. In accordance with the *Municipal Freedom of Information and Protection of Privacy Act* this information will be used solely to assess the student's Return to Learn and Return to Physical Activity. It will be retained in the Ontario Student Record [OSR] for one year after the student graduates or transfers out of the school. The Ministry of Education may also request school reports on concussion activity. If you have any questions or concerns about the collection of information on this form please contact the school principal.

# Appendix E – Documentation for a Diagnosed Concussion – Return to Learn/Return to Physical Activity Plan

**This form is to be used by parents/guardians and school contact, to communicate the child's/ward's progress through the plan.**

**The Documentation for a Diagnosed Concussion - Return to Learn/Return to Physical Activity Plan is a combined approach, with a collaborative effort between home and school.**

**Return to Learn Step 2a must be completed prior to the student returning to physical activity.**

**Each step must take a minimum of 24 hours (Note: Return to Learn Step 2b and Return to Physical Activity Step 2 occur concurrently).**

**All steps must be followed.**

## Step 1 – Return to Learn/Return to Physical Activity

- Completed at home.
- Cognitive Rest – includes limiting activities that require concentration and attention (e.g., reading, texting, television, computer, video/electronic games).
- Physical Rest – includes restricting recreational/leisure and competitive physical activities.

☐ My child has completed Step 1 of the Return to Learn/Return to Physical Activity Plan (cognitive and physical rest at home) and his/her **symptoms have shown improvement**. My child/ward will proceed to Step 2a – Return to Learn.

☐ My child has completed Step 1 of the Return to Learn/Return to Physical Activity Plan (cognitive and physical rest at home) and is **symptom free**. My child will proceed directly to Step 2b – Return to Learn and Step 2 – Return to Physical Activity.

***Parent/Guardian signature***: _____ Date: _____

***Comments:***_____

_____

***Principal Signature:*** _____

**Original filed in OSR once completed.**

Under the direction of the *Ontario Ministry of Education* and under the legal authority of the *Education Act*, Grand Erie District School Board collects this information in order to fulfil its commitment to promote the health and safety of students by raising awareness, identification, and prevention of concussion injuries, and managing diagnosed concussions. In accordance with the *Municipal Freedom of Information and Protection of Privacy Act* this information will be used solely to assess the student's Return to Learn and Return to Physical Activity. It will be retained in the Ontario Student Record [OSR] for one year after the student graduates or transfers out of the school. The Ministry of Education may also request school reports on concussion activity. If you have any questions or concerns about the collection of information on this form please contact the school principal.

**If at any time during the following steps symptoms return, please refer to the "Return of Symptoms" section on page 4 of this form.**

## Step 2a – Return to Learn

- Student makes gradual return to instructional day.
- Requires individualized classroom strategies and/or approaches which gradually increase cognitive activity.
- Physical rest– includes restricting recreational/leisure and competitive physical activities.

**If symptoms persist or worsen return to Step 1 and consult a physician (see page 4 of this form)**

☐ My child/ward has made a gradual return to his/her instructional day and has been receiving individualized classroom strategies and/or approaches and is **symptom free**. My child/ward will proceed to Step 2b – Return to Learn and Step 2 – Return to Physical Activity.

***Parent/Guardian signature:*** _____ ***Date:*** _____

***Comments:*** _____

_____

## Step 2b – Return to Learn

- Student returns to regular learning activities at school.

## Step 2 – Return to Physical Activity

- Student can participate in individual light aerobic physical activity only. **(At Home)**
- Student continues with regular learning activities.

☐ My child/ward is symptom free after participating in light aerobic physical activity. My child/ward is ready to proceed to Step 3 – Return to Physical Activity.

☐ **Appendix E will be returned to school contact to record progress through steps 3 and 4**

***Parent/Guardian signature:*** _____ ***Date:*** _____

***Comments:*** _____

_____

**If at any time during the following steps symptoms return, please refer to the "Return of Symptoms" section on page 4 of this form.**

## Step 3 – Return to Physical Activity

- Student may begin individual sport-specific physical activity only.

## Step 4 – Return to Physical Activity

- Student may begin activities where there is no body contact (e.g., dance, badminton); light resistance/weight training; non-contact practice; and non-contact sport-specific drills.

☐ **Student has successfully completed Steps 3 and 4 and is symptom free.**

☐ **Appendix E will be returned to parent/guardian to obtain medical doctor/nurse practitioner diagnosis and signature.**

***School Contact Name:*** _____ ***Date:*** _____

## Medical Examination:

☐ I, _____(medical doctor/nurse practitioner name) have examined _____ and confirm he/she continues to be symptom free and is able to return to regular physical education class/intramural activities/interschool activities in non-contact sports and full training/practices for contact sports.

***Medical Doctor/Nurse Practitioner Signature***: _____ ***Date:*** _____

***Comments:*** _____

_____

**This form (Appendix E), with medical doctor/nurse practitioner signature, is to be returned to the School Contact before the student may proceed to Step 5.**

**If at any time during the following steps symptoms return, please refer to the "Return of Symptoms" section on page 4 of this form.**

## Step 5 – Return to Physical Activity

- Student may resume regular physical education/intramural activities/interschool activities in non-contact sports and full training/practices for contact sports.

**This form (Appendix E) is to be returned to parent/guardian for final signature:**

☐ My child/ward is symptom free after participating in activities, in practice, where there is body contact and has my permission to participate fully, including participation in competition.

Parent/Guardian signature: _____ Date: _____

Comments: _____

_____

## Step 6 – Return to Physical Activity

- Student may resume full participation in contact sports with no restrictions.

## Return of Symptoms

☐ My child/ward has experienced a return of concussion signs and/or symptoms and has been examined by a medical doctor/nurse practitioner, who has advised a return to:

Step _____ of the Return to Learn/Return to Physical Activity Plan

***Parent/Guardian signature:*** _____ ***Date:*** _____

***Physician/Nurse Practitioner signature:*** _____ ***Date:*** _____

***Comments:*** _____

_____

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