# MEDICAL CONCUSSION ASSESSMENT FORM

**This form is to be provided to all parents/guardians of students suspected of having a concussion and returned to the School Administrator(s) after the medical examination of the student.**

_____ (student name) sustained a suspected concussion on

_____ (date) _____(time).

☐ As a result of your child experiencing a possible concussive event and demonstrating or reporting signs and/or symptoms, the student must be assessed as soon as possible by a medical doctor or nurse practitioner. In Canada, only medical doctors and nurse practitioners are qualified to provide a concussion diagnosis. Prior to returning to school, the parents/guardians must inform the school principal of the results of the medical assessment.

☐ It is suspected that your child may have received a concussion outside of school activities. As a result, your child must be seen by a medical doctor/nurse practitioner to assess their condition. Prior to returning to school, you must inform the School Administrator(s) of the result of the medical examination by presenting this completed form.

**Results of Medical Examination**

☐ My child/ward has been examined by a medical doctor/nurse practitioner and a concussion has not been diagnosed and therefore may resume full participation in learning and physical activity with no restrictions. **No further action required.**

☐ My child/ward has been examined by a medical doctor/nurse practitioner and a concussion has been diagnosed and therefore must begin a medically supervised, individualized and gradual Return to School/Return to Physical Activity Plan. As a result, I have completed:
- ☐ Appendix B: Medical Concussion Assessment Form
- ☐ Appendix C: Letter of Accommodation for Suspected/Diagnosed Concussions

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

Comments:

Medical doctor/Nurse Practitioner – Name: _____

Medical doctor/Nurse Practitioner – Phone Number: _____

Parent/Guardian name (print):_____ Date: _____

Parent/Guardian signature: _____

**THIS FORM MUST REMAIN PERMANENTLY IN THE OSR**

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# LETTER OF ACCOMMODATION FOR SUSPECTED/DIAGNOSED CONCUSSIONS

**If a student has been/is suspected of having a concussion, a parent/guardian must complete this form and return it to the School Administrator(s) prior to beginning the *Return to Learn (RTL) and Return to Physical Activity (RTPA) for Suspected/ Diagnosed Concussions* (Appendix E).**

## Fatigue

My child: ☐ tires easily ☐ has the normal amount of energy

My child has the most energy in the: ☐ morning ☐ afternoon ☐ evening

## Behaviour

My child: ☐ is easily frustrated ☐ is not easily frustrated

My child has been acting: ☐ the same ☐ different compared to before suspected concussion

## Memory

My child's/ward's memory seems: ☐ normal ☐ impaired

## Cognition

My child seems to understand complex thoughts and ideas: ☐ yes ☐ no

My child is able to read for: ☐ less than 1/2 hour ☐ 1/2 to 1 hour ☐ more than 1 hour

My child can handle different technologies (e.g., TV): ☐ yes ☐ no

My child can complete their homework: ☐ yes ☐ no

## Stamina

My child makes it through a day without a period of rest: ☐ yes ☐ no

## Social

My child is becoming socially isolated or is changing friends after suspected concussion: ☐ yes ☐ no

My child can handle busy/social environments: ☐ yes ☐ no

My child can handle environments of different noise levels (e.g., loud): ☐ yes ☐ no

My child can handle environments of different light levels (e.g., bright): ☐ yes ☐ no

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Parent/Guardian name (print): _____ Date: _____

Parent/Guardian signature: _____

Comments: _____

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# SUGGESTED ACCOMMODATIONS FROM MEDICAL TEAM

Patient Name: _____ Date of Evaluation: _____

The above-noted student is suffering from concussion-based symptoms and has recently undergone medical evaluation by a medical doctor or nurse practitioner. Based on this assessment the following is suggested to help the student return to school and minimize symptom provocation and enhance recovery.

Current Symptoms

- ☐ Headache
- ☐ Nausea
- ☐ Dizziness
- ☐ Fatigue
- ☐ Sleep Difficulties
- ☐ Sensitivity to Light
- ☐ Sensitivity to Noise
- ☐ Foggy
- ☐ Cognitive Difficulties
- ☐ Visual Dysfunction
- ☐ Difficulty Concentrating
- ☐ Emotional Changes

Attendance:

- ☐ No school until _____ then modified days
- ☐ Modified (as per below) or shortened as tolerated
- ☐ Full days as tolerated

Testing (Increased memory and attention problems may limit performance on highly demanding activities such as testing):

- ☐ No tests or quizzes
- ☐ Modified testing as needed:
  - ☐ Extra time
  - ☐ Quiet environment
  - ☐ Take home

Workload Reduction (may take student much longer to complete assignments and increased cognitive demand at this time may hinder recovery):

- ☐ Reduce or postpone overall amount of make-up work, class work and homework
- ☐ Shorten/modify tests and projects, or allow extra time to complete
- ☐ Limit notetaking requirements e.g. allow students to obtain notes ahead of time, get from another student

Breaks:

- ☐ As needed (e.g. If symptoms worsen during class, student may need to rest head on desk or leave class until symptoms improve)

Other Accommodations:

- ☐ Allow student to wear hat and /or sunglasses (sensitivity to light)
- ☐ Change setting on computer screen (brightness/contrast)
- ☐ No Physical Education class, Intramurals or Sport Team Participation
- ☐ Avoid busy environments (leave class early to avoid hallways, cafeteria and assemblies)
- ☐ Other: _____

Medical doctor/Nurse Practitioner – Name: _____

Medical doctor/Nurse Practitioner – Phone Number: _____

Parent/Guardian name (print): _____ Date: _____

Parent/Guardian signature: _____

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# FINAL MEDICAL EXAMINATION DOCUMENTATION

**This form is to be provided to all parents/guardians of students suspected of having a concussion and returned to the School Administrator(s) after Stage 4b of the *Return to Learn* and Stage 4 of the *Return to Physical Activity Plan* (Appendix E) and after the final medical examination of the student. The student must be medically cleared by a medical doctor/nurse practitioner *prior* to moving on to full participation in non-contact physical activities and full contact practices (RTPA Stage 5).**

Student Name: _____

Date: _____

## Results of Medical Examination

I have examined this student and confirm they are medically cleared to participate in the following activities:

- ☐ Full participation in Physical Education classes
- ☐ Full participation in Intramural physical activities (non-contact)
- ☐ Full participation in non-contact Interschool Sports (practices and competition)
- ☐ Full-contact training/practice in contact Interschool Sports

Comments:

_____

_____

_____

_____

**MEDICAL DOCTOR/NURSE PRACTITIONER**

Name: _____

Signature: _____ Date: _____

*A student who has received Medical Clearance and has a recurrence of symptoms or new symptoms appear, must immediately remove themselves from play, inform their parent/guardian/teacher/coach, and return to medical doctor or nurse practitioner for Medical Clearance reassessment before returning to physical activity.*

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