SUDBURY CATHOLIC DISTRICT SCHOOL BOARD
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Tool to Identify a Suspected Concussion[1]

This tool is a quick reference, to be completed by teachers, to help identify a suspected concussion and to communicate this information to parent/guardian. Be sure to fill out OSBIE accident report form and submit to the office as well.

Identification of Suspected Concussion

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.

1. Check appropriate box

An incident occurred involving _____ (student name) on _____ (date). He/she was observed for signs and symptoms of a concussion.

☐ No signs or symptoms described below were noted at the time. **Note:** Continued monitoring of the student is important as signs and symptoms of a concussion may appear hours or days later (refer to #4 below).

☐ The following signs were observed or symptoms reported:

Signs and Symptoms of Suspected Concussion	
Possible Signs Observed *A sign is something that is observed by another person (e.g., parent/guardian, teacher, coach, supervisor, peer).*	**Possible Symptoms Reported** *A symptom is something the student will feel/report.*
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 on page 2)* ☐ 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** _____	**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** _____

If any observed signs or symptoms worsen, call 911

2. Perform Quick Memory Function Assessment

Ask the student 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*: _____

3. Action to be Taken

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

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

In all cases of a suspected concussion, the student must be examined by a medical doctor or nurse practitioner for diagnosis and must follow the prescribed Concussion Management Procedures - Return to Learn and Return to Physical Activity. Form 1-1 must be returned to the school (Student Medical Clearance following Suspected Concussion)

4. Continued Monitoring by Parent/Guardian

- Students should be monitored for 24 – 48 hours following the incident as signs and symptoms can appear immediately after the injury **or may take hours or days to emerge.**
- **If any signs or symptoms emerge**, the student needs to be examined by a medical doctor or nurse practitioner as soon as possible that day.

5. Teacher/Coach/Supervisor name: _____

Teacher/Coach/Supervisor Signature: _____

Date: _____

6. Parent Signature: _____ (no signs/symptoms after 24hrs of observation)

Date: _____

This completed form must be signed and copied by the Teacher/Coach/Supervisor. Please keep the original and provide the copy to the parent.

This original and the returned signed parent copy must be filed in the student's OSR as per our school board policy.