TO BE COMPLETED BY HEALTH CARE PROVIDER IN THE EVENT OF A SUSPECTED CONCUSSION

According to the Centers for Disease Control, the American Academy of Neurology and the American Brain Injury Association, **a concussion is a mild traumatic brain injury: a disruption in normal brain function due to a blow or jolt to the head**. A concussion may cause altered mental status that may or may not involve loss of consciousness, along with other symptoms that may include headache; neck pain; balance problems or dizziness; nausea; vision/hearing problems; difficulty concentration, and /or recalling information; confusion; drowsiness; and exaggerated emotional responses (e.g. anger, irritability, crying, silliness) **Symptoms may be immediate or may develop over minutes and even weeks.** If not managed correctly, concussions can lead to serious, long-term and sometime life-threatening complications.

PLEASE BRING THIS FORM TO YOUR HEALTHCARE PROVIDER FOR COMPLETION

_____

Name: _____DOB:_____

Date of Injury: _____

Activity when Injury occurred: _____

Date of Initial Examination: _____

Diagnosis: _____

IF STUDENT HAS NOT SUSTAINED A HEAD INJURY AND REQUIRES NO FURTHER ACTION, PLEASE SIGN/DATE : _____

Please indicate any accommodations needed for student in school due to injury: (eg. Extra time to complete work, NO tests, rest in Health office etc): _____

_____

Date Student cleared to BEGIN RETURN TO PLAY PROTOCOL:

_____

Signature Health care provider Phone Number Fax Number Date