



Name	_____
Date of Injury	_____
Sport	_____
Parent/Guardian Name	_____
Phone	_____

Notification of Probable Head Injury for Interscholastic Athletics

Dear Parent/Guardian:

Based on our observations and/or incident described below, we believe your child exhibited signs and symptoms of a concussion while participating in _____. **It is important to recognize that blows to the head can also cause a variety of injuries other than concussions (e.g., neck injuries, more serious brain injuries)**

Due to the potential seriousness of this injury, it is important that you seek a physician's care, as soon as possible, to evaluate your child's signs and symptoms of a possible concussion or any other injuries related to this incident.

Please be advised that your child will not be allowed to return to play until he/she has no symptoms and has been cleared in writing by an authorized health care provider (physician, neuropsychologist, nurse practitioner, physician's assistant) for this injury. RETURN THIS FORM TO SCHOOL NURSE.

Description Incident/Injury: _____

When to Seek Care Urgently: If you observe any of the following danger signs, call your doctor or go to your emergency department immediately.

Headaches that worsen	Very drowsy, can't be awakened	Can't recognize people or places
Seizures	Repeated vomiting	Increasing confusion
Neck Pain	Slurred speech	Weakness/numbness in arms/legs
Unusual behavior change	Significant irritability	Less responsive than usual

Common Signs & Symptoms: It is common for a student with a concussion to have one or many symptoms.

Physical		Cognitive	Emotional	Sleep
Headache	Visual Problems	Feeling mentally foggy	Irritability	Drowsiness
Nausea/Vomiting	Fatigue/Feeling tired	Feeling slowed down	Sadness	Sleeping less than usual
Dizziness	Sensitivity to lights/noise	Difficulty remembering	More emotional	Sleeping more than usual
Balance Problems	Numbness/Tingling	Difficulty concentrating	Nervousness	Trouble falling asleep

***NOTE:** Signs and symptoms may be delayed for hours or even days. Please watch your child for delayed symptoms, and seek medical advice, immediately, should they appear

Please feel free to contact me if you have any questions. I can be reached at: _____

Employee Name and Title

Date

TO BE COMPLETED BY THE AUTHORIZED HEALTH CARE PROVIDER:

Name: _____ Signature: _____ Date: _____

Diagnosis: (Please Check) No Concussion Concussion Other _____

Re: If "concussion" is checked, before returning to normal activities the Medical Clearance for Gradual Return to Interscholastic Athletics Participation Following Concussion form must be completed. If "other" is checked, medical clearance from an authorized health care provider is also required.

Distribution: White-Parent; Yellow-Athletic Trainer; Pink-School Health Room; Goldenrod-AD