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 a licensed health care provider (LHCP) (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

*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 __________________________

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

<table>
<thead>
<tr>
<th>Physical</th>
<th>Cognitive</th>
<th>Emotional</th>
<th>Sleep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>Visual Problems</td>
<td>Feeling mentally foggy</td>
<td>Irritability</td>
</tr>
<tr>
<td>Nausea/Vomiting</td>
<td>Fatigue/Feeling tired</td>
<td>Feeling slowed down</td>
<td>Sadness</td>
</tr>
<tr>
<td>Dizziness</td>
<td>Sensitivity to lights/noise</td>
<td>Difficulty remembering</td>
<td>More emotional</td>
</tr>
<tr>
<td>Balance Problems</td>
<td>Numbness/Tingling</td>
<td>Difficulty concentrating</td>
<td>Nervousness</td>
</tr>
</tbody>
</table>

TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER (LHCP):

Name: __________________________ Signature: __________________________ Date: __________________________

Diagnosis: (Please Check) No Concussion Concussion Other Phone: __________________________

Date student may return to school: __________________________ Note: Student will be removed from all sports and physical education activities at school until medically cleared. School will implement standard academic accommodations unless specific accommodations are requested.

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 a licensed health care provider is also required.

If “concussion” is checked, please go to the CCPS Athletic website for helpful information regarding concussions.

Distribution: White–Parent; Yellow–Athletic Trainer; Pink–School Health Room; Goldenrod–Athletic Director