

LSS 33

Ref: AP825-101

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| **Concussion – Tool to Identify a Suspected Concussion 1** |

**Identification of a 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 **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:

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| **SIGNS AND SYMPTOMS OF SUSPECTED CONCUSSION** |
| **Possible Signs Observed***A sign is something that is observed by another person**(eg., 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*** 
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02/2015

**IF ANY OBSERVED SIGNS OR SYMPTOMS WORSEN, CALL 911.**

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**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 concussion protocol described in Administrative Procedures AP-825-101.

**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.** Respondent name:

 Respondent signature: Date:

Principal signature: Date:

1*Adapted from McCroy et. al, Consensus Statement on Concussion in Sport. Br J Sports Med 47 (5), 2013*

***Information Collection Authorization:*** *The personal information contained on this form has been collected in accordance with the Municipal Freedom of Information and Protection of Privacy Act, and Policy and Program Memorandum 158, titled School Board Policies on Concussion. The information is collected for the sole purpose of helping to identify a suspected concussion.*

*Questions regarding the information contained on this form should be directed to the Principal.*

**USER: Medical Staff, Principal, Teachers**

**ORIGINAL: Parent/Guardian/Student, if over the age of 18      COPY: OSR**

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