

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:

SIGNS AND SYMPTOMS OF SUSPECTED CONCUSSION

Possible Signs Observed <i>A sign is something that is observed by another person (eg., parent/guardian, teacher, coach, supervisor, peer).</i>	Possible Symptoms Reported <i>A symptom is something the student will feel/report.</i>
<p>Physical</p> <ul style="list-style-type: none"> <input type="checkbox"/> vomiting <input type="checkbox"/> slurred speech <input type="checkbox"/> slowed reaction time <input type="checkbox"/> poor coordination or balance <input type="checkbox"/> blank stare/glassy-eyed/dazed or vacant look <input type="checkbox"/> decreased playing ability <input type="checkbox"/> loss of consciousness or lack of responsiveness <input type="checkbox"/> lying motionless on the ground or slow to get up <input type="checkbox"/> amnesia <input type="checkbox"/> seizure or convulsion <input type="checkbox"/> grabbing or clutching of head <p>Cognitive</p> <ul style="list-style-type: none"> <input type="checkbox"/> difficulty concentrating <input type="checkbox"/> easily distracted <input type="checkbox"/> general confusion <input type="checkbox"/> cannot remember things that happened before and after the injury (<i>see Quick Memory Function Assessment on page 2</i>) <input type="checkbox"/> does not know time, date, place, class, type of activity in which he/she was participating <input type="checkbox"/> slowed reaction time (e.g., answering questions or following directions) <p>Emotional/Behavioural</p> <ul style="list-style-type: none"> <input type="checkbox"/> strange or inappropriate emotions (e.g., laughing, crying, getting angry easily) <p>Other</p> <ul style="list-style-type: none"> <input type="checkbox"/> _____ 	<p>Physical</p> <ul style="list-style-type: none"> <input type="checkbox"/> headache <input type="checkbox"/> pressure in head <input type="checkbox"/> neck pain <input type="checkbox"/> feeling off/not right <input type="checkbox"/> ringing in the ears <input type="checkbox"/> seeing double or blurry/loss of vision <input type="checkbox"/> seeing stars, flashing lights <input type="checkbox"/> pain at physical site of injury <input type="checkbox"/> nausea/stomach ache/pain <input type="checkbox"/> balance problems or dizziness <input type="checkbox"/> fatigue or feeling tired <input type="checkbox"/> sensitivity to light or noise <p>Cognitive</p> <ul style="list-style-type: none"> <input type="checkbox"/> difficulty concentrating or remembering <input type="checkbox"/> slowed down, fatigue or low energy <input type="checkbox"/> dazed or in a fog <p>Emotional/Behavioural</p> <ul style="list-style-type: none"> <input type="checkbox"/> irritable, sad, more emotional than usual <input type="checkbox"/> nervous, anxious, depressed <p>Other</p> <ul style="list-style-type: none"> <input type="checkbox"/> _____

IF ANY OBSERVED SIGNS OR SYMPTOMS WORSEEN, 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-825-001.

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