APPENDIX B (A.P. 3-27)
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CONCUSSION MEDICAL EXAMINATION DOCUMENTATION REQUEST FORM

This form is to be provided to all parents/guardians of students suspected of having a concussion and returned to the School Administrator(s) after the medical examination of the student.

______________________________ (student name) sustained a suspected concussion on

______________________________ (date) ______________________(time).

☐ As a result, your child/ward must be seen by a medical doctor/nurse practitioner to assess their condition. Prior to returning to school, you must inform the School Administrator(s) of the result of the medical examination by presenting this completed form.

☐ It is suspected that your child/ward may have received a concussion outside of school activities. As a result, your child/ward must be seen by a medical doctor/nurse practitioner to assess their condition. Prior to returning to school, you must inform the School Administrator(s) of the result of the medical examination by presenting this completed form.

Results of Medical Examination

☐ My child/ward has been examined by a medical doctor/nurse practitioner and no concussion has been diagnosed and therefore may resume full participation in learning and physical activity with no restrictions. **No further action required.**

☐ My child/ward has been examined by a medical doctor/nurse practitioner and a concussion has been diagnosed and therefore must begin a medically supervised, individualized and gradual Return to Learn/Return to Physical Activity Plan. As a result, I have completed:
  - ☐ Appendix B: Concussion Medication Examination Documentation Request Form
  - ☐ Appendix C: Letter of Accommodation for Suspected/Diagnosed Concussions
  - ☐ Appendix D: Final Medical Examination Documentation

Parent/Guardian name (print):______________________________ Date: ____________________

Parent/Guardian signature: ______________________________

Comments: ____

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FOR OFFICE USE ONLY - THIS FORM MUST REMAIN PERMANENTLY IN THE OSR

LETTER OF ACCOMMODATION FOR SUSPECTED/DIAGNOSED CONCUSSIONS

If a student has been/is suspected of having a concussion, a parent/guardian must complete this form and return it to the School Administrator(s) prior to beginning the *Return to Learn/Return to Physical Activity Plan* (Appendix E).

Fatigue

My child/ward: ☐ tires easily ☐ has the normal amount of energy

My child/ward has the most energy in the: ☐ morning ☐ afternoon ☐ evening

Behaviour

My child/ward: ☐ is easily frustrated ☐ is not easily frustrated

My child/ward has been acting: ☐ the same ☐ different compared to before suspected concussion

Memory

My child's/ward's memory seems: ☐ normal ☐ impaired

Cognition

My child/ward seems to understand complex thoughts and ideas: ☐ yes ☐ no

My child/ward is able to read for: ☐ less than 1/2 hour ☐ 1/2 to 1 hour ☐ more than 1 hour

My child/ward can handle different technologies (e.g., TV): ☐ yes ☐ no

My child/ward can complete their homework: ☐ yes ☐ no

Stamina

My child/ward makes it through a day without a period of rest: ☐ yes ☐ no

Social

My child/ward is becoming socially isolated or is changing friends after suspected concussion: ☐ yes ☐ no

My child/ward can handle busy/social environments: ☐ yes ☐ no

My child/ward can handle environments of different noise levels (e.g., loud): ☐ yes ☐ no

My child/ward can handle environments of different light levels (e.g., bright): ☐ yes ☐ no

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Parent/Guardian name (print):______________________ Date: ______________

Parent/Guardian signature: ______________________

Comments: ____

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FINAL MEDICAL EXAMINATION DOCUMENTATION

This form is to be provided to all parents/guardians of students suspected of having a concussion and returned to the School Administrator(s) after Step 5 of the *Return to Learn/Return to Physical Activity Plan* (Appendix E) and after the final medical examination of the student.

______________________________ (student name) sustained a suspected concussion on

______________________________ (date) ______________________(time).

Results of Medical Examination

☐ My child/ward has been examined by a medical doctor/nurse practitioner who has confirmed my child/ward is symptom free and is able to return to regular physical education class/intramural activities/interschool activities for both non-contact and contact sports.

☐ My child/ward has been examined by a medical doctor/nurse practitioner who has confirmed my child/ward continues to have symptoms and has recommended my child/ward return to Step ____ of the *Return to Learn/Return to Physical Activity Plan* (Appendix E).

Parent/Guardian name (print):______________________ Date: ____________________

Parent/Guardian signature: ______________________

Comments: ______________________________

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