Appendix C – Tool to Identify a Suspected Concussion

This tool is a quick reference, to be completed to help identify a suspected concussion and to communicate this information to parent/guardian.

Identification of Suspected Concussion – 3 Step Process

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 **any one or more** of the signs or symptoms outlined in the chart below **and/or** the failure of the Quick Memory Function Assessment.

First, assess the danger to the victim and the rescuer, and then check airway, breathing and circulation.

Step 1: Check appropriate box

An incident occurred involving _____ (student name) on _____ (date) at _____ (time).

He/she was observed for signs and symptoms of a concussion.

- ◯ No signs or symptoms described below were noted at the time of assessing the student/athlete.
  Note: *Continued monitoring of the student/athlete is important as signs and symptoms of a concussion may appear hours or days later (refer to #3 b) on the reverse).*
- ◯ The following signs were observed or symptoms reported:

Possible Signs Observed *A sign is something is observed by another person (e.g. 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-(call 911 immediately) ❑ lying motionless on the ground or slow to get up ❑ amnesia ❑ seizure or convulsion- (call 911 immediately) ❑ 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)* ❑ 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 _____ **Sleep Disturbance** ❑ drowsiness ❑ insomnia	**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 _____ **Sleep Disturbance** ❑ drowsy ❑ sleeping more/less than usual ❑ difficulty falling asleep PLEASE TURN OVER
If any observed signs or symptoms worsen, call 911.	

Step 2: Perform Quick Memory Function Assessment

Ask the student the following questions and record the answers below. Failure to answer any one of these questions correctly may indicate a concussion.

> **Note**: It may be difficult for younger students (under the age of 10), students with special needs or students for whom English is not their first language to communicate how they are feeling. Select the most appropriate questions for the student based on his/her ability to respond.

Primary/Junior:

- What is your name? Answer: _____
- How old are you? Answer: _____
- What grade are you in? Answer: _____
- What is your teacher's name? Answer: _____
- Other_____? Answer: _____

Intermediate/Senior:

- 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*:_____

Comments:

_____

_____

_____

Step 3: Action to be taken

Signs observed or Symptoms reported:

If there are **any** signs observed or symptoms reported, or if the student/athlete fails to answer any of the above questions correctly:

- a concussion should be suspected;
- the student/athlete must be immediately removed from play and must not be allowed to return to play that day even if the student/athlete states that he/she is feeling better; and
- the student/athlete must not leave the premises without parent/guardian (or emergency contact) supervision.

In all cases of a suspected concussion, the student/athlete must be examined by a medical doctor or nurse practitioner for diagnosis and must follow the Student Concussion and Head Injury Policy.

No signs observed or symptoms reported:

- Student to be monitored for 24 hours and removed from physical activity (where teacher/coach determines monitoring is applicable or where teacher/coach is not sure).
- Monitoring of the student/athlete to take place at home by parents and at school by school staff. To monitor for signs and symptoms parents/guardians can use the chart on the front of this information form**.**
- If any signs or symptoms emerge, the student/athlete needs to be examined by a medical doctor or nurse practitioner as soon as possible that day.

Comments:

_____

_____

_____

School Contact/Teacher Advisor Name: _____ ***Date:*** _____

Following the completion of this form (Appendix C), an OSBIE Incident Report form must be completed, indicating that the tool has been completed and the parent/guardian has received copies of Appendix C and Appendix D2.

Under the direction of the *Ontario Ministry of Education* and under the legal authority of the *Education Act*, Grand Erie District School Board collects this information in order to fulfil its commitment to promote the health and safety of students by raising awareness, identification, and prevention of concussion injuries, and managing diagnosed concussions. In accordance with the *Municipal Freedom of Information and Protection of Privacy Act* this information will be used solely to assess the student's Return to Learn and Return to Physical Activity. It will be retained in the Ontario Student Record [OSR] for one year after the student graduates or transfers out of the school. The Ministry of Education may also request school reports on concussion activity. If you have any questions or concerns about the collection of information on this form please contact the school principal.

***The original copy is filed with the principal** ***Duplicate copy provided to parent/guardian**