

THE SABIS® INTERNATIONAL CHARTER SCHOOL

160 Joan Street
Springfield, MA 01129
Tel: (413) 783-2600 Fax: (413) 783-2555
Email: tcampagna@sics-sabis.net

PRE-PARTICIPATION HEAD INJURY/CONCUSSION REPORTING FORM

This form should be completed by the student's parent or legal guardian. It must be submitted to the Athletic Director or coach *prior* to the start of *each sport season* a student plans to participate in.

Student's Name	Sex	Date of Birth
Address	Telephone	
Sport	Grade	

Concussion Regulations and Parent/Student-Athlete Education

In June of 2011, the state passed new **MANDATORY** concussion regulations that require parents and athletes to be aware of the signs and symptoms of concussions. By checking one of the options below and signing this form, you attest to the fact that you have viewed one of these links or if unable to view the link; have picked up a paper copy at the Athletic Director's office.

_____ http://www.cdc.gov/concussion/HeadsUp/online_training.html

_____ <http://www.nfhslearn.com/electiveDetail.aspx?courseID=15000>

_____ http://www.cdc.gov/concussion/pdf/Parents_Fact_Sheet-a.pdf*

_____ I have picked up a copy of Heads Up parent fact sheet

YOU MUST HAVE CHECKED ONE OPTION ABOVE TO BE ELIGIBLE TO PARTICIPATE IN SPORTS

Has student ever experienced a traumatic head injury (a blow to the head)?

Yes ___ No ___ If yes, when? Dates (month/year) _____

Has student ever received medical attention for a head injury?

Yes ___ No ___ If yes, when? Dates (month/year) _____

If yes, please describe the circumstances:

Was student diagnosed with a concussion? Yes ___ No ___

Yes, when? Dates (month/year) _____

Duration of symptoms (headache, concentration issues, fatigue, etc) for most recent concussion:

Parent/Guardian: Name (please print) _____

Signature/Date _____

Student: Name (please print) _____

Signature/Date _____

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Report of Head Injury During Sports Season Form

This form is to report a head injury (other than minor cuts or bruises) that occurs during an athletic event. It should be returned to the Athletic Director and reviewed by the school nurse.

For Coaches: Please complete this form immediately after the game or practice for head injuries that result in the student being removed from play due to *possible* concussion.

For Parents/Guardians: Please complete this form if your child has a head injury outside of school related athletic activities.

Student's Name	Sex	Date of Birth
Address	Telephone	
Sport	Grade	

Date of injury: _____

Did the incident take place during a school activity? Yes ___ No ___

If so, where did the incident take place? _____

Please describe the nature and extent of injuries to the student:

For Parents/Guardians:

Did the student receive medical attention? Yes ___ No ___

If yes, was a concussion diagnosed? Yes ___ No ___

I HEREBY STATE THAT TO THE BEST OF MY KNOWLEDGE, MY ANSWERS TO THE ABOVE QUESTIONS ARE COMPLETE AND CORRECT.

Name of person completing the form: _____
(Please Print)

Signature/Date: _____

Relationship to student: (please circle one) Coach ___ Parent ___

PLEASE RETURN THIS FORM TO THE ATHLETIC DIRECTOR

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**POST SPORTS-RELATED HEAD INJURY
MEDICAL CLEARANCE AND
AUTHORIZATION FORM**

This Medical clearance should only be provided *after* a graduated return to play plan has been completed and the student has been symptom free at all stages (at rest and during exertion). This form may only be completed by a licensed physician, nurse practitioner or neuropsychologist involved in the student’s recovery.

Student’s Name	Sport	Sex	Date of Birth	Grade
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Date of injury _____ Nature and extent of injury _____

Symptoms (check all that apply):

- ___ Nausea or vomiting ___ Headaches ___ Light/noise sensitivity
- ___ Dizziness/balance problems ___ Double/blurred vision ___ Fatigue
- ___ Feeling sluggish/”in a fog” ___ Change in sleep patterns ___ Memory problems
- ___ Difficulty concentrating ___ Emotional changes ___ Other _____

Duration of symptom(s): _____

Diagnosed with **concussion**? _____

If yes, date student completed *graduated return to play* plan: _____

Name of Physician/Practitioner: _____

Address _____ Telephone _____

I HEREBY AUTHORIZE THE ABOVE NAMED STUDENT FOR RETURN TO PE AND ATHLETIC ACTIVITIES

Signature: _____ Date: _____

PLEASE RETURN THIS FORM TO THE ATHLETIC DIRECTOR