BLACK GOLD REGIONAL DIVISION NO. 18

Form 319-2

Observed Signs or Symptoms - Documentation of Concussion Monitoring/Medical Examination

NOTE: *This form is provided to the parent/guardian, in conjunction with Concussion Guidelines for Parents and Parents Guide to Dealing with Concussions. A parent/guardian signature is required for this form to be accepted by the school.*

Student Name:_____ **Date:** _____

The above-named student has sustained a blow to the head, face or neck or a blow to the body that transmits a force to the head and, as a result, may have suffered a concussion.

Results of the Concussion Recognition Tool to identify a suspected concussion:

This student has demonstrated signs and symptoms of a suspected concussion and must be seen by a medical doctor or nurse practitioner.

Results of Medical Examination:

☐ The above-named student has been examined and **no concussion has been diagnosed** and therefore may resume full participation in learning and physical activity with no restrictions.

☐ The above-named student has been examined, **a concussion has been diagnosed**.

Doctor/Nurse Practitioner Signature: _____ Date: _____

Comments:

_____

_____

As the parent/guardian of the above-named student, I acknowledge that, if a concussion is diagnosed, Black Gold Regional Division No. 18 requires that my child/ward follow the Return to Learn/Return to Physical Activity Plan as attached and may not return to full physical activity until a note from a medical doctor or nurse practitioner is provided.

Parent/Guardian Signature: _____ Date: _____