



Student-Athlete _____
Date of injury _____
Sport _____
Parent/guardian name _____
Home Phone _____

Notification of Probable Head Injury for Interscholastic Athletics

Dear Parent:

It is important to recognize that blows to the head can cause a variety of injuries other than concussions (e.g., neck injuries, more serious brain injuries). Please be sure to see your doctor as soon as possible for any other medical concerns.

Based on our observations and/or incident described below, we believe your son/daughter exhibited signs and symptoms of a concussion while participating in _____. Since a physician at school has not evaluated your son/ daughter, it is important that you seek a physician’s care as soon as possible.

Please be advised that your son/daughter will not be allowed to return to play until he/she has no symptoms and have been cleared in writing by an authorized health care provider (physician, neuropsychologist, nurse practitioner, physician’s assistant) for this type of injury.

Description of Incident/ Injury: _____

When to Seek Care Urgently: If you observe any of the following signs, call your doctor or go to your emergency department immediately.

Headaches that worsen	Very drowsy, can't be awakened	Can't recognize people or places
Seizures	Repeated vomiting	Increasing confusion
Neck pain	Slurred speech	Weakness/numbness in arms/legs
Unusual behavior change	Significant irritability	Less responsive than usual

Common Signs & Symptoms: It is common for a student with a concussion to have one or many symptoms.

Physical		Cognitive	Emotional	Sleep
Headache	Visual Problems	Feeling mentally foggy	Irritability	Drowsiness
Nausea/Vomiting	Fatigue/ Feeling tired	Feeling slowed down	Sadness	Sleeping less than usual
Dizziness	Sensitivity to light/ noise	Difficulty remembering	More emotional	Sleeping more than usual
Balance Problems	Numbness/Tingling	Difficulty concentrating	Nervousness	Trouble falling asleep

Please feel free to contact me if you have any questions. I can be reached at: _____

Employee Name and Title

Date

TO BE COMPLETED BY THE AUTHORIZED HEALTH CARE PROVIDER:

Name: _____ Signature: _____ Date: _____

Diagnosis: (Please Check) No Concussion ___ Concussion ___ Other _____

Re: If “concussion” is checked, before returning to normal activities the Medical Clearance for Gradual Return to Interscholastic Athletics Participation Following Concussion form must be completed. If “other” is checked, medical clearance from an authorized health care provider is also required.

Distribution: White – Parent; Pink – AAM; Goldenrod - School Health Room