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

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