Longfields-Davidson Heights Secondary School
149 Berrigan Drive, Nepean ON, K2J 5C6, (613) 843-7722

CONCUSSION Appendix D

Documentation of Medical Examination

On ________________________ (date), ________________________ (student name) sustained a suspected concussion. As a result, this student must be seen by a medical doctor or nurse practitioner. Prior to returning to school, the parent/guardian must inform their child's Guidance Counsellor, of the results of the medical examination by completing the following:

Results of the medical examination

- ❑ My child has been examined and **no concussion** has been diagnosed and therefore may resume full participation in learning and physical activity with no restrictions.
- ❑ My child has been examined and **a concussion has been diagnosed** and therefore must begin a medically supervised, individualized and gradual *Return to Learn / Return to Physical Activity Plan* (see Concussion Appendix E).
- ❑ I understand that the Ottawa-Carleton District School Board recommends that my child receive medical authorization before returning to school. I have chosen not to obtain such medical authorization and give permission for my child to assume full participation in the learning and physical activity with no restrictions during the core instructional day. I understand that this does not include extra-curricular activities where there may be requirement for medical authorization, dependent on the nature of the extra-curricular activity.

PARENT/GUARDIAN SIGNATURE: ________________________

DATE: ________________________

COMMENTS:____
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- *Return this completed page to your child's guidance counsellor.*

Freedom of Information Notice
The information provided on this form is collected pursuant to the Board's education responsibilities as set out in the Education Act and its regulations. This information is protected under the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA) and will be utilized only for the purpose of managing student learning and well being. Access to this information will be limited to those who have an administrative need, to the student to whom the information relates and the parent(s)/guardian (s) of a student who is under 18 years of age. Any questions with respect to this information should be directed to the school principal.

Longfields-Davidson Heights Secondary School
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CONCUSSION Appendix E

Documentation for a Diagnosed Concussion

Return to Learn

- *If at any time during the following steps, symptoms return, please refer to the Return of Symptoms section of this form.*
- *Each step must take a minimum of 24 hours.*

Step 1

- This step is completed at home.
- Cognitive Rest which includes limiting activities that require concentration and attention (e.g. reading, texting, television, computer, electronic games).
- Physical Rest which includes restricting recreational, leisure, and competitive activities.

Step 2

- ☐ My child has completed Step 1 of Return to Learn (cognitive and physical rest at home) and his/her **symptoms have shown improvement**. My child is ready to return to school, but requires individualized classroom strategies and/or approaches to gradually increase cognitive activity. I will arrange these accommodations with my child's guidance counsellor. Proceed to Return to Learn – Step 3.

- ☐ My child has completed Step 1 of Return to Learn (cognitive and physical rest at home) and is **symptom free**. My child will return to regular learning activities at school. If applicable, proceed to Return to Physical Activity – Step 2 by contacting Athletic Director, Joel Graham (613) 843-7722 x 3124

PARENT/GUARDIAN SIGNATURE: ___________________________

DATE: ___________________________

COMMENTS:____
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- *Return this completed page to your child's guidance counsellor.*

Return to Learn (continued)

- *If at any time during the following steps, symptoms return, please refer to the Return of Symptoms section of this form.*
- *Each step must take a minimum of 24 hours.*

Step 3

❑ My child has been receiving individualized classroom strategies and/or approaches, and is now **symptom free**. My child will return to regular learning activities at school.

STUDENT NAME: _________________________

PARENT/GUARDIAN SIGNATURE: _________________________

DATE: _________________________

COMMENTS:____
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- *Return this completed page to your child's guidance counsellor.*
- *Guidance counsellor will inform classroom teachers of the change*
- *If applicable, proceed to Return to Physical Activity – Step 2 by contacting Athletic Director, Joel Graham (613) 843-7722 x 3124*

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CONCUSSION Appendix E

Documentation for a Diagnosed Concussion

Return to Physical Activity

- *Return to Learn must be completed prior to Return to Physical Activity.*
- *If at any time during the following steps, symptoms return, please refer to the Return of Symptoms section of this form.*
- *Each step must take a minimum of 24 hours.*

Step 1

- This step is completed at home.
- Cognitive Rest which includes limiting activities that require concentration and attention (e.g. reading, texting, television, computer, electronic games).
- Physical Rest which includes restricting recreational, leisure, and competitive activities.

Step 2

- To be arranged with Athletic Director, Joel Graham (613) 843-7722 x 3124
- Student can participate in individual light aerobic physical activity only.
- Student continues with regular leaning activities.

❑ My child is **symptom free** after participating in light aerobic physical activity. My child will proceed to Return to Physical Activity – Step 3.

STUDENT NAME: ___________________________

PARENT/GUARDIAN SIGNATURE: ___________________________

DATE: ___________________________

COMMENTS:____
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- *Return this completed page to Athletic Director, Joel Graham.*

Return to Physical Activity (continued)

Step 3

- Student may begin individual sport-specific physical activity only.

Step 4

- Student may begin activities where there is no body contact (e.g. dance, badminton); light resistance/weight training; non-contact practice; and non-contact sport-specific drills.

  - ❑ Student has successfully completed Steps 3 and 4 and is **symptom free**. Page 6 of this form will be returned to the parent/guardian to obtain medical doctor/nurse practitioner diagnosis and signature.

STUDENT NAME: ___________________________

TEACHER SIGNATURE: ___________________________

DATE: ___________________________

COMMENTS:____
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- *Return this completed page to Athletic Director, Joel Graham.*

Return to Physical Activity (continued)

Step 5
Medical Examination:

- ❑ I, _________________________ (medical doctor/nurse practitioner) have examined _________________________ (student name) and confirm that he/she continues to be symptom free and is able to return to regular physical education class; intramural activities; interschool activities in non-contact sports; and full training and practices for contact sports.

MEDICAL DOCTOR/NURSE PRACTITIONER SIGNATURE: _________________________

DATE: _________________________

COMMENTS:____
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Step 6
- Student may resume full participation in contact sports with no restrictions.

- *Return this completed page to Athletic Director, Joel Graham.*

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CONCUSSION Appendix E

Documentation for a Diagnosed Concussion

Return of Symptoms

My child has experienced a return of concussion signs and/or symptoms and has been examined by a medical doctor/nurse practitioner who has advised a return to:

Return to Learn – Step ___
Return to Physical Activity – Step ___

STUDENT NAME: ________________________

PARENT/GUARDIAN SIGNATURE: ________________________

DATE: ________________________

COMMENTS:____
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- *Return this completed page to your child's guidance counsellor.*

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