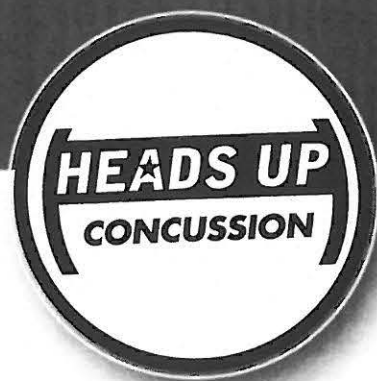


# PARENT & ATHLETE CONCUSSION INFORMATION SHEET



## WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

## WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports one or more symptoms of concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury. The athlete should only return to play with permission from a health care professional experienced in evaluating for concussion.

### DID YOU KNOW?

- Most concussions occur without loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

## SYMPTOMS REPORTED BY ATHLETE:

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Sensitivity to light
- Sensitivity to noise
- Feeling sluggish, hazy, foggy, or groggy
- Concentration or memory problems
- Confusion
- Just not "feeling right" or is "feeling down"

## SIGNS OBSERVED BY COACHING STAFF:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes
- Can't recall events prior to hit or fall
- Can't recall events after hit or fall

Michigan Department  
of Community Health



Rick Snyder, Governor  
James K. Haveman, Director

► **"IT'S BETTER TO MISS ONE GAME  
THAN THE WHOLE SEASON"**

## CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously)

## WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

1. If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says s/he is symptom-free and it's OK to return to play.
2. Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, and playing video games, may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.
3. Remember: Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

## WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. They can even be fatal.

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STUDENT-ATHLETE NAME PRINTED

---

STUDENT-ATHLETE NAME SIGNED

---

DATE

---

PARENT OR GUARDIAN NAME PRINTED

---

PARENT OR GUARDIAN NAME SIGNED

---

DATE

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HEADS UP

TO LEARN MORE GO TO

Content Source: CDC's Heads Up Program. Created through a grant to the CDC Foundation from the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

**Wayne - Westland Community Schools**  
**Medication Authorization Form**

When medication is a necessity during school time, administration of the medication by school personnel requires physician direction. This must be renewed each school year.

Student Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

=====

**TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER**

Name of medication: \_\_\_\_\_

Reason for medication (optional): \_\_\_\_\_

Form of medication/treatment:

☐ Tablet/capsule   ☐ Liquid   ☐ Inhaler   ☐ Injection   ☐ Nebulizer  
☐ Other: \_\_\_\_\_

DOSE/TIME (to be given at school)

Restrictions and/or important side effects: ☐ None anticipated

☐ Yes, Please describe: \_\_\_\_\_

Special Storage requirements: ☐ None   ☐ Refrigerate

Other: \_\_\_\_\_

=====

Physicians Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: (\_\_\_\_\_) \_\_\_\_\_

**STAMP OF EXAMINING PHYSICIAN:**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

=====

**To be completed by parent/guardian:**

I request that (name of child) \_\_\_\_\_ receive the above medication at school according to standard school policy.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

=====

**To be completed by school office:**

Date Form Received: \_\_\_\_\_

Date Medication Received: \_\_\_\_\_

## HEALTH APPRAISAL

**Dear Parent or Guardian:** The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. **(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)**

## PERSONAL

CHILD'S NAME (Last, First, Middle)		DATE OF BIRTH (mm/dd/yy)
		/ /
ADDRESS (Number & Street)	(City)	(ZIP Code)
		MI
		TODAY'S DATE (mm/dd/yy)
		/ /
PARENT/GUARDIAN (Last, First, Middle)		HOME TELEPHONE NUMBER
		( )
ADDRESS (Number & Street)	(City)	(ZIP Code)
		MI
		WORK TELEPHONE NUMBER
		( )

**SECTION I - HEALTH HISTORY**

<b>Yes</b>	<b>No</b>	<b>Resolved</b>	# Is your child having any of the problems listed below?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Eczema or Frequent Skin Rashes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10 Speech Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11 Menstrual Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12 Dental Problems: Date of Last Exam      /      /
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please describe): _____ _____
<input type="checkbox"/>	<input type="checkbox"/>		Does your child take any medication(s) regularly?
			Reason for Medication  
			/      /
<b>Parent/Guardian Signature</b> _____			Date _____


→

<b>Birth History:</b>
Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____
If yes, list medications: _____ _____ _____ _____ _____
Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No         Examiner's Initials: _____

## SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

## Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION	Visual Acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT	Height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Muscle Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Date: ____/____/____	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	HEARING	Audiometer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Date: ____/____/____	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD PRESSURE	Reading: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS	Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN	Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Date: ____/____/____	Albumin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date: ____/____/____	Neg: <input type="checkbox"/> Pos: <input type="checkbox"/> _____ mm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL	Level _____ ug/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>NOTE:</b> Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.						

### Examinations and/or Inspections

Essential Findings Deviating from Normal:	Exam Date:      /      /
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**SECTION III - IMMUNIZATIONS**

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.\*

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2		Influenza (IIV/LAIV)	1	3
				2	4
DTaP/DTP/DT/Td	1	4	Meningococcal (MCV4 / MPSV4)	1	2
	2	5			
	3	6	Human Papillomavirus (HPV4/HPV2)	1	3
Tdap	1			2	
Haemophilus Influenzae type b (HIB)	1	3	OTHER Vaccines	Type of Vaccine(s)	Date of Vaccine(s)
	2	4	Specify Date & Type	1	
Polio (IPV/OPV)	1	3		2	
	2	4		3	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable		
	2	4	*NOTE: According to Public Act 368 of 1976, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your child's school or local health department.		
Rotavirus (RV1/RV5)	1	3			
	2				
Measles, Mumps, Rubella (MMR)	1	2	Parent/Guardian refused immunizations: <input type="checkbox"/>		
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____					
I certify that the immunization dates are true to the best of my knowledge					
Health Professional's Signature _____			Title _____		Date _____

**SECTION IV - RECOMMENDATIONS**

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain.
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Other
Other Recommendations		

**SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)**

I have examined \_\_\_\_\_ child's name \_\_\_\_\_'s teeth. As a result of this examination, my recommendation for treatment is \_\_\_\_\_

\_\_\_\_\_ Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_

**PHYSICIAN'S SIGNATURE**

Examiner's Signature _____	Date _____	Examiner's Name (Print or Type) _____	Degree or License _____
Number & Street _____	City _____	MI _____	ZIP Code _____ Telephone _____

Information required for:

**Early On** - Hearing and Vision Status; Diagnosis; Health Status

**Child Care Licensing** - Physical Exam, Restrictions, Immunizations

**Head Start/Early Head Start** - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

\*\*\*\*\*  
Developed in Cooperation with the Departments of Human Services, Education, Community Health, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.