Halton District School Board

Form C-3 *Documentation of Monitoring/Medical Examination Form*

This form is provided to the parent/guardian, in conjunction with Tool to Identify a Suspected Concussion (Form C-2). A Parent/guardian signature is required for this form to be accepted by the school.

_________________________ (student/athlete name) __________________ (date), 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 initial assessment using Tool to Identify a Suspected Concussion:

- ☐ NO SIGNS OR SYMPTOMS OBSERVED AT TIME OF INCIDENT.
  However, signs or symptoms can occur later within a 24 hour period. Your child/ward is not to participate in physical activity for a 24 hour period. While at home parent/guardian is to monitor their child/ward using the Tool to Identify a Suspected Concussion (Form C2). School Staff will monitor the student/athlete while at school.

Actions: **If no signs/symptoms occur during the monitoring period**, parent/guardian is to complete the following Results of Monitoring section prior to their child/ward returning to school.

Results of Monitoring

☐ As the parent/guardian, my child/ward has been observed for the 24 hour period, and no signs/symptoms have been observed.

Parent/Guardian signature: _______________________________ Date: ______________________

Comments: ____

- ☐ SIGNS OR SYMPTOMS OBSERVED: _______ AT TIME OF INCIDENT
  _______DURING THE 24 HOUR MONITORING PERIOD

For the signs and/or symptoms observed at the time of incident/during the 24 hour monitoring period, refer to the Tool to Identify a Suspected Concussion(Form C-2) provided by teacher/coach/supervisor

Actions: Your child/ward must be seen by a medical doctor or nurse practitioner as soon as possible with the Results of Medical Examination form (below) returned to the school principal after medical examination.

Results of Medical Examination

☐ My child/ward 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/ward 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 (Form C-4)

Parent/Guardian signature: _____________________________Date: ______________________

Comments:____