

# CMP STUDENT-ATHLETE CONCUSSION MANAGEMENT PROGRAM INJURY ASSESSMENT PACKAGE

NAME OF STUDENT-ATHLETE \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME OF SCHOOL/TEAM \_\_\_\_\_

SPORT/ACTIVITY \_\_\_\_\_

As a result of the following incident the CMP Student-Athlete Concussion Management Protocol has been initiated for the above-named student-athlete.

DETAILS OF INCIDENT \_\_\_\_\_ DATE OF INCIDENT: \_\_\_\_\_

This information package is being provided to the Parent/Guardian of the student-athlete.

It is advised that the student-athlete see a medical physician at the earliest possible time in order to assess any possible damages and determine if a concussion has occurred. Included with this package is a Sideline Assessment that was done when the student-athlete was removed from play. This assessment should be presented to the physician.

Also included with this package are four forms that must be filled out and signed before the student-athlete will be permitted to begin gradual physical training for the purpose of returning to competition. The Parent/Guardian will ensure that the forms are signed by the respective authorities and returned to the student-athlete's CMP Coach or as directed.

- A Medical Clearance to Resume Physical Training for the physician to sign
- A Parental Clearance to Resume Physical Training for the parent/guardian of the student-athlete to sign
- A Self-Declaration to Resume Physical Training for the student-athlete to sign.
- A School CMP Leader Clearance to Resume Physical Training for the school principal.

The Parent/Guardian will make arrangements with the person signing this document to schedule a Post-Injury ImPACT Test for the above-named student-athlete within 24 to 72 hours of the date of the incident.

In the meantime, the student-athlete should be monitored carefully for signs of concussion-like symptoms and should get as much physical and cognitive rest as possible.

It is suggested that both the Parent/Guardian and the Student-Athlete review the information about the protocols and procedures that are recommended as part of the CMP Student-Athlete Concussion Management Program which can be found online at [www.concussionmanagementpartners.com](http://www.concussionmanagementpartners.com)

SIGNATURE OF SCHOOL CMP COACH \_\_\_\_\_

NAME (PRINT) \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

# MEDICAL CLEARANCE TO RESUME GRADUAL PHYSICAL TRAINING FOR RETURN TO SPORTS COMPETITION

NAME OF STUDENT-ATHLETE \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME OF SCHOOL/TEAM \_\_\_\_\_

SPORT/ACTIVITY \_\_\_\_\_

DETAILS OF INJURY \_\_\_\_\_ DATE OF INJURY: \_\_\_\_\_

DETAILS OF INJURY	DATE OF INJURY: _____
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The above-named student-athlete was examined and/or treated for symptoms of a possible concussion.

I certify that, as of this date, the above named student-athlete does not exhibit any medical reason which would prevent the beginning of a gradual physical training process for the purpose of returning to sports participation.

NOTES / DIRECTIONS FROM EXAMINING PHYSICIAN

NOTES / DIRECTIONS FROM EXAMINING PHYSICIAN
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SIGNATURE OF EXAMINING PHYSICIAN \_\_\_\_\_

NAME OF EXAMINING PHYSICIAN: \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

# PARENT/GUARDIAN CLEARANCE TO RESUME GRADUAL PHYSICAL TRAINING FOR RETURN TO SPORTS COMPETITION

NAME OF STUDENT-ATHLETE \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME OF SCHOOL/TEAM \_\_\_\_\_

SPORT/ACTIVITY \_\_\_\_\_

DETAILS OF INJURY

DATE OF INJURY: \_\_\_\_\_

DESCRIPTION OF HOME CARE / MONITORING FOR CONCUSSION-LIKE SIGNS OR SYMPTOMS

I certify that I am a parent/guardian of the above named student-athlete whom I have been monitoring for signs or symptoms that would indicate to me that he/she is suffering from a concussion.

As of this date he/she does not show or self-admit any concussion-like signs or symptoms.

Therefore, as the student-athlete's parent/guardian, I hereby give clearance for him/her to begin a gradual physical training process for the purpose of returning to sports participation and will continue to monitor him/her for the return of any concussion-like signs or symptoms.

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_

NAME OF PARENT/GUARDIAN \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

# STUDENT-ATHLETE SELF-DECLARATION OF CLEARANCE TO RESUME GRADUAL PHYSICAL TRAINING FOR RETURN TO SPORTS COMPETITION

NAME OF STUDENT-ATHLETE \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME OF SCHOOL/TEAM \_\_\_\_\_

SPORT/ACTIVITY \_\_\_\_\_

DETAILS OF INJURY \_\_\_\_\_ DATE OF INJURY: \_\_\_\_\_

DESCRIPTION OF CONCUSSION-LIKE SIGNS OR SYMPTOMS

I certify that I am the above-named student-athlete and I am aware of the usual signs and/or symptoms which would indicate that I have a concussion.

I certify that, as of this date, and to the best of my knowledge, I am not aware of any signs and/or symptoms which would prevent me from beginning of a gradual physical training process for the purpose of returning to sports participation.

I declare that I will follow a gradual physical training process for the purpose of returning to sports participation under the direction and supervision of my School CMP Coach and I will not hesitate to admit to the return of any concussion-like signs or symptoms.

SIGNATURE OF STUDENT-ATHLETE \_\_\_\_\_

NAME OF STUDENT-ATHLETE \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

# SCHOOL CMP LEADER CLEARANCE TO RESUME GRADUAL PHYSICAL TRAINING FOR RETURN TO SPORTS COMPETITION

NAME OF STUDENT-ATHLETE \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

NAME OF SCHOOL/TEAM \_\_\_\_\_

SPORT/ACTIVITY \_\_\_\_\_

DETAILS OF INJURY	DATE OF INJURY: _____
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DESCRIPTION OF MONITORING FOR CONCUSSION-LIKE SIGNS OR SYMPTOMS
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The above-named student-athlete has been monitored for signs or symptoms of a possible concussion.

I certify that, as of this date, to my knowledge, the above named student-athlete does not exhibit any signs or symptoms which would prevent the beginning of a gradual physical training process for the purpose of returning to sports participation.

Therefore, as the School CMP Leader, I hereby give clearance for him/her to begin a gradual physical training process for the purpose of returning to sports participation and will ask his/her School CMP Head Coach to continue to monitor him/her for the return of any concussion-like signs or symptoms.

SIGNATURE OF SCHOOL CMP LEADER \_\_\_\_\_

NAME OF SCHOOL CMP LEADER \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_

# CMP STUDENT-ATHLETE CONCUSSION MANAGEMENT PROGRAM NOTIFICATION TO CLASSROOM TEACHERS

NAME OF STUDENT-ATHLETE \_\_\_\_\_

NAME OF SCHOOL/TEAM \_\_\_\_\_

SPORT/ACTIVITY \_\_\_\_\_

As a result of the following incident the CMP Student-Athlete Concussion Management Protocol has been initiated for the above-named student-athlete. This means that there may be a need for accommodations to be made to the regular classroom routines in order to compensate for concussion symptoms.

DETAILS OF INCIDENT

DATE OF INCIDENT: \_\_\_\_\_

This notification is being given to all classroom teachers of the above-named student-athlete. It is possible that a number of accommodations may be required during the recovery period. The following is a list of suggestions that are being provided in order to assist in the rehabilitation process.

- Find an alternative to testing or delaying testing until after recovery
- Allow someone to copy notes for the student athlete or permit taping of lessons
- No physical education classes, including weight training or aerobics
- Do not assign homework unless the student-athlete indicates that he/she is capable of doing some
- Once the student is able to do some homework, provide written instructions
- Have the student sit near the front of the room or where there are the fewest distractions
- If the lighting bothers the student, perhaps the lights over the student can be dimmed
- Allow the student to wear sunglasses or a hat with a visor if the light bothers him/her
- Allow the student to visit with the counsellor whenever he/she requests
- Allow the student to move from class to class before the hallway gets crowded
- Allow the student to take lunch in a quiet place with one or two friends only
- waive time constraints for tests and assignments – take as long as necessary to complete
- be flexible with respect to assignment due dates
- don't expect the student to catch up on missed lessons – adjust the requirements for him/her
- provide preferential seating for close monitoring and decreased distractions
- allow the student-athlete to leave the room if he/she is feeling overwhelmed
- Provide regular sessions with the counsellor to discuss concerns and challenges
- The classroom teacher should provide individualized attention as much as possible

We appreciate the cooperation of all teachers and staff in accommodating for the needs of our child at this time. More information can be found under the Teachers' Guide section on the web site at [www.concussionmanagementpartners.com](http://www.concussionmanagementpartners.com)

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_

NAME OF PARENT/GUARDIAN \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_