

Dear Parents/Guardians,

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| Your child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has sustained a potential head injury or suspected concussion on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. |
| *Day and Date* |

At St Philip’s, we use the HeadCheck app (developed in collaboration with the Murdoch Children’s Research Institute and the AFL) and the Concussion Recognition Tool (developed by the Concussion in Sport Group) to guide us in the identification and immediate management of suspected concussion.

Your child is currently exhibiting the following symptoms of a suspected concussion:

* …………………………………………… ………………………………………………….
* …………………………………………… ………………………………………………….
* …………………………………………… ………………………………………………….

As per St Philip’s school policy, any student with a suspected concussion:

* Is immediately removed from sporting activity until assessed medically.
* Will not return to any activity with risk of head contact until assessed medically or monitored by parents/guardians for 24 hours with no further symptoms.

Students with a suspected concussion should **NOT**:

* Be left alone initially (at least for the first 3 hours). Worsening of symptoms should lead to immediate medical attention.
* Be sent home by themselves. They need to be with a responsible adult.
* Drive a motor vehicle until cleared to do so by a healthcare professional.

It is recommended you seek medical attention to confirm or rule out a concussion.  
  
***The following details must be completed and presented to STUDENT ACCESS when your child returns to school.***

My child has been seen by the GP/Doctor and **HAS** a diagnosed concussion.

My child has been seen by the GP/Doctor and does **NOT** have a concussion and is medically cleared to return to regular activity.

My child has **NOT** been seen by the GP/Doctor and has been monitored for 24 hours with no further symptoms of a possible concussion.

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| I give permission for my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to return to school on this |
| *Student’s Name* |
| day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ with / without *(please tick)* a graded return to school program. |
| *Day and Date* |

Signed by Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_