

San Jose Charter Academy

PARENT/GUARDIAN CONCUSSION & HEAD INJURY FORM

Student Name: _____

Grade: _____ Home Base Teacher: _____

Date: _____

Parent/Guardian Information

Parent/Guardian Name: _____

Phone: _____

Email: _____

Emergency Contact: _____

Emergency Phone: _____

Concussion & Head Injury Information

A concussion is a type of brain injury that can occur after a bump, blow, or jolt to the head or body. Symptoms may include headache, dizziness, nausea, balance problems, confusion, difficulty concentrating, sensitivity to light or noise, changes in sleep, or changes in mood or behavior.

I understand that:

- ☐ My child should report any symptoms of a concussion or head injury to a teacher, coach, athletic staff member, or other school employee.
- ☐ If a concussion or significant head injury is suspected, my child will be removed from physical activity/ sporting event and should not return to play until appropriately evaluated and cleared according to applicable medical and school requirements.
- ☐ I will monitor my child for signs and symptoms following a head injury.

☐ I will seek medical attention if I have concerns about my child's condition or if emergency warning signs develop.

☐ I will notify the school if my child has been diagnosed with a concussion or other head injury by a healthcare professional.

☐ I understand that my child's return to physical activity may need to be gradual and may require medical clearance or other documentation according to school policy.

Previous History

Has your child ever had a concussion or significant head injury?

☐ No ☐ Yes

If yes, approximately when? _____

Has your child ever been advised by a healthcare professional to limit physical activity because of a concussion or head injury?

☐ No ☐ Yes

If yes, please explain: _____

Current Head Injury

Is your child currently experiencing any symptoms related to a recent head injury?

☐ No ☐ Yes

If yes, please describe:

Date of most recent head injury: _____

Was your child evaluated by a healthcare professional?

☐ No ☐ Yes

If yes, date of evaluation: _____

Healthcare Provider: _____

Parent/Guardian Acknowledgment

By signing below, I acknowledge that I have received and reviewed information regarding concussion and head injuries. I understand the importance of reporting symptoms and following appropriate medical and school procedures before my child returns to physical activity.

Parent/Guardian Signature: _____

Date: _____

Student Signature: _____

Date: _____

SCHOOL USE ONLY

Date Received: _____

Staff Member: _____

Additional Documentation Required: ☐ No ☐ Yes

Medical Clearance Provided: ☐ No ☐ Yes ☐ N/A

Return-to-Activity Plan Needed: ☐ No ☐ Yes

Notes:
