





### SUMMIT ACADEMY/SUMMIT ACADEMY NORTH SCHOOLS

Locations in Flat Rock, Huron Township and Romulus Central Administration Offices: 30100 Olmstead, Bldg. B, Flat Rock, MI 48134

734-379-9766

Mike Bravo Principal

Web: http://www.summit-academy.com

Parent	nt's Name	<del></del>
Studer	ent's NameGrade	_
School	ol District Student is coming from	
1.	I. Do you feel your home district provided the program you felt was necessary to meet you academic and social needs, in an environment that you felt was safe?	
2.	2. Why did you choose to leave your home district?	— ··
3.	. Were we recommended to you by anyone in your home district?	
lf s	f so, by whom?	
4.	. How did you hear about us?	
5.	. Did your child receive Special Education Services at their home district?YesNo	_
if yes, p	please answer the following:	
Do you If no, w	u feel your child received appropriate special education services while attending your home why?	district?
Thank-y Academ	you-for taking the time to fill out this survey. We know that your child's experience at Sum my/Summit Academy North Schools will be a rewarding one!	mlt
Sincerel	ely,	

Start Date: Complete Date:



## Summit Academy /Summit Academy North Schools

Circle One
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North Elem K-5 Flat Rock K-8

11

Middle 6-8 High 9-12

ACADEMY NORTH	Enrollment Application 2014-2015 School Year	<u> </u>

		STUDENT INFORMATIO		<del></del>	·
	ALL STUDENT NAME FIELDS	SIVIUS I BE AS THEY APP	EAR ON THE BIR	TH CERTIFICATE	
First Name	Middle Name ***KII	Last Name NDERGARTEN STUDENTS	Suffix MUST BE 5 BY OC		14-2015 YEAR.
Address	City	State	Zip	() Phone	·
Date of Birth	Gender Place of B			l District of Reside	
School Attending:(N	ame & District) Building Na	me, City, State			
<del></del>		HOME LANGUAGE			
YesN s the primary langu	e language a language ot lo If yes, what is t vage used in your child's h lo If yes, what is t	hat language? nome or environment a	language othe	r than English?	
	STUDENTI	NFORMATION-SPECI	AL SERVICES		
oes your child receiv	ve Special Education Service	esYesNo	Date of La	ast IEP	
heck the boxes befo	re each service that your ch	ild receives: (check all tha	at apply)		
Speech and Lang	juage Services (SL) L	earning Disabled Suppor	t (LD) Er	notional Impairme	nt Support
ADD/ADHD	Social Work (SW)	Physical/O	ccupational The	rapy (PT/OT)	
ly child DOES NOT r	eceive special services; but	they DO HAVE A 504 PLA	AN for individual	s with disabilities	
omments					

Did you withdraw from another school to avoid discipline charges or consequences?YESN  If so, what was the violation?	
Has your child ever had a long term suspension or expulsion from another school?YESNO  RESIDENCY/CITIZENSHIP/ETHNICITY  Please answer both questions to comply with state and federal regulations. Is your child HISPANIC OR LATIN?YESNO (COMPLETE THE NEXT QUESTIO)  Is your child African American Asian Caucasian Pacific Islander Amer. Indian  Is your child a US Citizen?YesNo / Is your child a State of Michigan Resident?Yes  Has your child ever attended ANY Summit Academy or Summit Academy North School?Yes	NO
RESIDENCY/CITIZENSHIP/ETHNICITY  Please answer both questions to comply with state and federal regulations. Is your child HISPANIC OR LATIN? YES NO (COMPLETE THE NEXT QUESTIO) Is your child African American Asian Caucasian Pacific Islander Amer. Indian Is your child a US Citizen? Yes No / Is your child a State of Michigan Resident? Yes Has your child ever attended ANY Summit Academy or Summit Academy North School? Yes	
Please answer both questions to comply with state and federal regulations.  Is your child HISPANIC OR LATIN?YESNO (COMPLETE THE NEXT QUESTIO)  Is your child African American Asian Caucasian Pacific Islander Amer. Indian  Is your child a US Citizen?YesNo / Is your child a State of Michigan Resident?YesNo / Is your child ever attended ANY Summit Academy or Summit Academy North School?Yes	)
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ls your child a US Citizen?YesNo / Is your child a State of Michigan Resident?Ye	N)
Has your child ever attended ANY Summit Academy or Summit Academy North School?Yes_	
	esNo
If so, when?Which location?	No
PRIMARY CONTACT PARENT/GUARDIAN INFORMATION	
Relationship First Name Last Name	<del></del>
Address City State Zip Home Phone	
Work Phone Cell Phone Email Address	<del></del>
**ARE THERE CUSTODY ISSUES THE SCHOOL SHOULD KNOW ABOUT? YES NO	
SECONDARY CONTACT PARENT/GUARDIAN INFORMATION	
Relationship First Name Last Name	
Address City State Zip Home Phone	
Vork Phone Cell Phone Email Address (used for school notification system)	

		ICY CONTACT INFORMATION ition to Parents/Guardians)	Į	
My child may be release	d to the following people:			
Relationship	Name	Home	 Cell	/
Relationship	Name	Home	<i> </i>	Work
Relationship	Name	Home	Cell	Work
	STUDEN	IT HEALTH INFORMATION		
retion? Yes No If yes, plea Poes your child have a ducation or athletics	any visual or hearing problem ase explain: any health conditions which ? Yes No If yes, please	may limit participation in explain:	strenuous act	ivities such as physical
oes your child have a tention? es No If yes, plea	ny other health conditions of see explain:	or medications which shou	ıld be brought	to the schools
as your child had chid	cken pox? Yes No		<del></del>	
	TUTORIN	IG/REMEDIATION NEEDS		<u>,                                     </u>
as your child ever atter	ded any tutoring or remediati			

How long were they in the program?\_\_\_\_\_

Summit Academy North DOES NOT have my permission to use a like Please check only if you DO NOT want your child to be used in any Su newsletter or on the website.  SIBLING INFORMATION  Relationship Name School Site  Relationship Name School Site  Relationship Name School Site  To the best of my knowledge the information on this application is true.  Parent/Guardian Signature Date  Date  Office Use Only  Inth Certificate  Inmunizations  Oney of Legal Docs, if custody Issues  Jaken By  ater Received  Jones Office Use  One SS OFFICE USE  NEY  Initials  Initials  Retake D  Retake Score	_		·
Relationship Name School Site  Relationship Name School Site  Relationship Name School Site  Signature Signature  O the best of my knowledge the information on this application is true.  arent/Guardian Signature Date  Fifice Use Only  Initials  Placema Assessmin Date Take  Score  Signature Score  Retake D  Retake Score  Retake Score	ness or p mmit Ad	photogi cademy	raph of my child advertisement,
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JENNIFER M. GRANHOLM

# STATE OF MICHIGAN DEPARTMENT OF COMMUNITY HEALTH LANSING

JANET OLSZEWSKI

### **IMMUNIZATION WAIVER FORM**

#### INSTRUCTIONS TO PARENTS OR GUARDIANS:

Vaccine-preventable diseases are still with us. In many cases, they cause disability or death. Immunizations are one of our most cost-effective measures to protect children from harmful diseases. A high proportion of children must be immunized to prevent outbreaks of disease in school settings and other places where children work and play closely together.

Sections 9208 and 9211 of the Michigan Public Health Code require that a parent, guardian, or person in *loco parentis* applying to have a child registered for the first time in a Michigan school or in a program of group residence, care, or camping in this state shall present to officials at the time of registration or not later than the first day of school or program enrollment, a certificate of immunization verifying that the child has been vaccinated against diphtheria, tetanus, pertussis, measles, mumps, rubella, polio, hepatitis B, and varicella (chickenpox). Vaccination for Pneumococcal conjugate is also required for preschool-aged children. The *Haemophilus influenza* type b is not required for the 2009-20010 reporting season.

A parent or guardian wishing to exempt his or her child from a particular vaccination must provide a written statement indicating the religious or philosophical objections to the vaccination(s). A child who has been exempted from a vaccination is considered susceptible to the disease or diseases for which the vaccination offers protection. The child may be subject to exclusion from the school or program, if the local and or state public health authority advises exclusion as a disease control measure.

By signing this waiver, you acknowledge that you are placing your child and others at risk of serious illness should he or she contract a disease that could have been prevented through proper vaccination.

#### ALL INFORMATION MUST BE FILLED IN BELOW.

		ing my child, checked below:		37 1		, born		immunized against the
шьецьег	s i nave	спескей оетом:	(First & Last	Name)			(Birth	Date)
	Ø	Diphtheria			Measles		□	Hepatitis B
	$\square$	Tetanus			Mumps			Haemophilus influenzae type b
	$\Box$	Pertussis -			Rubella			Pneumococcal Conjugate
		Varicella (chicken	pox)		Polio		$\Box$	Meningococcal
	$\Box$	Tdap						J
Reason:		<del> </del>						
							•	
	<u>.</u>	· · · · · · · · · · · · · · · · · · ·			<u> </u>	-		
Parent(s	s)/Guare	dian(s) Name:	. ,	<b></b>				
		·						
							<del></del>	
Child's A	Address.	re here				Telephone:_		
		If different from po	irent/guardian					
Parent o	r Guare	dian's Signature				<u>-</u>		Date Signed

Preschool Program or Licensed Day Care Center OR School Name (Required)

File in the child's permanent record and send a copy to your local health department.

DCH-0716

AUTHORITY: P.A. 368 of 1978, Part 92

Rev. 1/2010



### STATEMENT OF CONDUCT

Conduct Resulting in Long Term Suspension or Expulsion in Other School Districts Student Name Grade Enrolling in
A student who has engaged in misconduct resulting in expulsion or long-term suspension in another school district, or who has withdrawn from said school district before such misconduct was established by and appropriate hearing, which misconduct, if true, is sufficient gravity to pose a threat to the health or welfare of students or district personnel, or makes the presence of the student in the school district disruptive to the educational process, may be subject to a suspension or expulsion due process hearing prior to admission in Summit Academy North. Such conduct, if established, may make a student ineligible to enroll in and attend Summit Academy North.  In order to process the student's enrollment, the parent or legal guardian (if the student is under 18 years of age) or
student (if the student is 18 or older) must answer the questions below:
<ol> <li>Has the student been convicted of a crime, or are any felony charges pending against the student?         Yes No If the answer is yes: Date of Charge Charge         Has the student been expelled from another school district?         Yes No If the answer is yes, please explain</li></ol>
3. Has the student received a long-term suspension (more than 10 days) from another school district?  Yes No If the answer is yes, please explain
4. Has the student withdrawn from a school district in lieu of being charged with conduct that may have resulted in expulsion or long-term suspension?  Yes No If the answer is yes, please explain
Restrictions for enrollment may apply. Approval may be needed from the Administration.
his form must be signed by former building principal or administrator.
According to our records, we verify the information provided is correct.
According to our records, we can verify the information is not correct.
the student has been suspended or expelled for any reason, please forward appropriate disciplinary documentation
gnature of Former Administrator



# Summit Academy North Schools Residency Questionnaire



High School Phone: 734-955-1730 Fax: 734-955-1737 Middle School Phone: 734-955-1712 Fax: 734-955-1729 Elementary
Phone 734-789-1428 Fax: 734-789-1431

Student's Name:	····	· · · · · · · · · · · · · · · · · · ·		
Date of Birth:			Sex:	
Home School (based on current	residence)	-		
School of Origin (last school atte				
Siblings of student				
Name:	Sch	ool:		
Name:	Sch	ool:		
Name:	Sch	ool:		
The answers to the following be eligible to receive under	ng questions can r the McKinney-V	help determine the ento Act 42 U.S.C.	ne services this student r . 114 <mark>35</mark> .	may
1. Is this student's home address a ter	nporary living arrangen	nent?	□Yes □No	
	ent due to loss of housir	ng or econ <mark>omic hards</mark> hip?	' ⊡Yes □No	
2. Is this a temporary living arrangement				
3. Is this student in temporary or eme			□Yes □Nọ	
<ul><li>3. Is this student in temporary or eme</li><li>4. As a student, are you living with so</li><li>If you answered YES to <u>any</u> of the</li></ul>	meone other than your e above questions, pl	parent or legal guardian? lease complete the rei	□Yes □No	
<ul> <li>3. Is this student in temporary or eme</li> <li>4. As a student, are you living with sor</li> <li>If you answered YES to <u>any</u> of the</li> <li>If you answered NO to all of the a</li> <li>1. Where is this student currently</li> </ul>	meone other than your e above questions, pl above questions, plea	parent or legal guardian? lease complete the rei ase stop here.	□Yes □No mainder of this form.	<del></del>
3. Is this student in temporary or eme 4. As a student, are you living with sor  If you answered YES to any of the If you answered NO to all of the a  1. Where is this student currently  In a motel/hotel	meone other than your e above questions, pl above questions, plea	parent or legal guardian? lease complete the renase stop here. □With more than o	□Yes □No mainder of this form.  ne famlly in a house or apartment	<del>- , -</del>
3. Is this student in temporary or eme 4. As a student, are you living with sor  If you answered YES to any of the If you answered NO to all of the a  1. Where is this student currently  In a motel/hotel  In a shelter	meone other than your e above questions, plea above questions, plea v living? (check box)	parent or legal guardian? lease complete the renase stop here. □With more than o □Moving from plac	□Yes □No mainder of this form.  ne family in a house or apartment e to place	
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### **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 II 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.)

									DATE OF BIRTH (mm/	άάλλ	'n
									/	1	
ADDRESS (Number & Street)	(Ci	ty)					(ZIP C	ode)	TODAY'S DATE (mm/c		)
PARENT/GUARDIAN (Last, First, M	ddie)								HOME TELEPHONE N	/ WMB	EΑ
									( )		
ADDRESS (Number & Street)	(Cit	ly)	_	_		_	(ZIP ¢	ode)	WORK TELEPHONE N	IUME	ER
							MI		( )		
	SECT	rio	N I	<u>- H</u>	EΑ	LTI	HISTORY				
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	having any of the problems list					$\dashv$	Birth History:				
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□ □ □ 3 Eczema or Fr	<del></del>					$\dashv$		<del></del>	·····		
□ □ □ 4 Convulsions/s				<u>-</u>					<del></del>		
□ □ □ 5 Heart Trouble						-1					
□ □ □ 6 Dlabetes				_							
□ □ □ 7 Frequent Cold	is, Sore Throats, Earaches (4 or n	nore	pe pe	r ye	ar)		Are there any current	or past diag	nosis(es)   Yes	0 1	do
	assing Urine or Bowel Movemen	ts					If yes, please describ				
□ □ □ 9 Shortness of I								·			
☐ ☐ ☐ 10 Speech Proble					_	_					
☐ ☐ ☐ 11 Menstrual Pro									·		
☐ ☐ ☐ 12 Dental Proble											
L C E Ontel Disease des	cribej.					-					
			-		_	- {					
□ □ Does your child to	ake any medication(s) regularly?					1	If yes, list medication	R'			
Reason for Medication	, , , , , , , , , , , , , , , , , , , ,					= =		-	<del>-</del>		
											_
			1	•			Was the health history	y reviewed by	a health profession	al?	
Parent/Guardian	Signature D	ate					☐ Yes ☐ No	Examine	r's Initlals:		_
SECT	ION II - PHYSICAL EXAMINA Required for Child	ATI Ca	ON re a	, IN	ISF He	EC ad 8	TION, TESTS AND M Start / Early Head Star	EASUREM!	ENTS		
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⇒ Yvas Child tested for:	Test results:	Įž	Æ	5	_	وو	Was child tested for:	Test results:	<u> </u>	2	1 %
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VISION	Visual Actuity	╀	╀	-	U		HEIGHT & WEIGHT		-	1—	
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b	Muscle Imbalance						Other:	Weight Other	<u></u>		-
Date: / /	Muscle Imbalance Other:	-  -  -						<del></del>	c)		
Date: / /	Muscle Imbalance Other: Audiomater				. 0 0		Other:	<del></del>	<b>c</b> )		
Date: / / HEARING	Muscle Imbalance Other: Audiomater				. 0 0		Other: HEMOGLOBIN / HEMATOCRIT	Other	c)		
Date: / /  MEARING  Date: / /  Date: / /  URINALYSIS	Muscle Imbalance Other: Audiometer Other:						Other: HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE	Other Reading:	<b>c</b> )		
Date:/	Muscle Imbalance Other: Audiomater Other: Sugar						Other: HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE	Other Reading:			
Date: / /  HEARING  Date: / /  URINALYSIS  Date: / /  BLOOD LEAD LEVEL	Muscle Imbalance Other: Audiomater Other: Sugar Albumin Microscopic			1			Other: HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE TUBERCULIN Date: / / Blood lead level required for	Other  Reading:  Type:  Neg: □ Pos.:  all chilloren en	rolled in Medicaid mus	st be	tes
Date: / /  HEARING  Date: / /  URINALYSIS  Date: / /  BLOOD LEAD LEVEL	Muscle Imbalance Other: Audiomater Other: Sugar Albumin			<b>→</b>	O O NC	D D TE:	Other: HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE TUBERCULIN Date: / / Blood lead level required for and two years of age, or or siy tested. All children under	Other  Reading:  Type:  Nag.: □ Pos.:  all children en nece between it age six living in	rolled in Medicaid mus	age	) If
Date: / /  HEARING  Date: / /  URINALYSIS  Dale: / /  BLOOD LEAD LEVEL	Muscle Imbalance Other: Audiometer Other: Sugar Albumin Microscopic Level ug/di	ling			O NC at preat t	D D D D D D D D D D D D D D D D D D D	Other: HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE TUBERCULIN Date: / / Blood lead level required for and two years of age, or or siy tested. All children under ame intervals as listed above	Other  Reading:  Type:  Nag.: □ Pos.:  all children en nece between it age six living in	rolled in Medicaid mus	age	) If
Date: / /  HEARING  Date: / /  URINALYSIS  Date: / /  BLGOD LEAD LEVEL	Muscle Imbalance Other: Audiomater Other: Suger Albumia Microscopic Levelug/di	linal			O NC at preat t	D D D D D D D D D D D D D D D D D D D	Other: HEMOGLOBIN / HEMATOCRIT BLOOD PRESSURE TUBERCULIN Date: / / Blood lead level required for and two years of age, or or siy tested. All children under	Other  Reading:  Type:  Nag.: □ Pos.:  all children en nece between it age six living in	rolled in Medicaid mus	age	) If

Statements such as "t	JP-TO-DATE" o	SECTION I	II - IMMUNIZATIONS ccepted. Admission to school may be denied	on the basis of this Info	ormation.*
VACCINES (Circle Type)		NTE ADMINISTERED	VACCINES (Circle Type)	DATE ADM	MINISTERED
Hepatitis B	1	3	Hepatitis A (Hep A)	1	2
(Нер В)	2		1.0 0010.111	1	3
	1	4	Influenza (TIV/LAIV)	2	4
DTaP/DTP/DT/Td	2	5	Meningococcal (MCV4 / MPSV4)	1	2
<u> </u>	3	6	Human Papillomavirus	1	3
Tdap	_11		(HPV4/HPV2)	2	
Haemophilus Influenzae	1	3		Type of Vaccine(s)	Date of Vaccine(s
type b (HIB)	2	4	OTHER Vaccines	î	
Polio	1	3	Specify Date & Type	2	
(IPV/OPV)	2	4		3	
Pneumococcal Conjugate	1 .	3	Indicate and attach physician diagnosis	or laboratory evidence of	immunity as applicable
(PCV7/PCV13)	2	4	*NOTE: According to Public Act 368 of 1		····
Rotavirus (RV1/RV5)	1	3	the first time must be adequately	/ Immunized, vision teste	d and hearing tested.
	2		Exemptions to these requirement objections, provided that the wait	its are granted for medica	oi, religious and other
Measles, Mumps, Rubella (MMR)	1	2	delivered to school administrator	rs. Forms for these exemp	epareo, signed and ptions ere avallable at
Varicella (Chickenpox)	1	2	your child's school or local healt	ih department.	
History of Chickenpox Disease? Di Yea	□ No If yes, d	fale:	Parent/Guardian refused immunizations:	D	····
Is there any defect of vision, hear	ing or other condit	(Required for Child Care	RECOMMENDATIONS and Head Start/Early Head Start) th by sealing or other actions? Il yes, please explain		
Should the child's activity be restricted if yes, check and explain degree of	ricled because of a	any physical defect or liness?	☐ Gymnasium ☐ Swimming Pool ☐ Competit	<del></del>	
ther Recommendations					
<del></del>	SECTION V	- DENTAL EXAMINATIO	N AND RECOMMENDATIONS (OPTIC	NAL)	
ave examined	d's name	's teeth.	As a result of this examination, my recommendation	n for treatment is:	
	Dentist's Signa	elure		/ / Dale	<u> </u>
		PHYSICIA	N'S SIGNATURE		
Examiner's Signature	Đ	Dale	Examiner's Name (Print c	or Type)	Degree or License
Number & Street			MI	<del></del> ()-	

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.

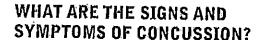


IE CUMULATIVE FILES INCLUDING BUT NOT LIMTED TO:  Parent- Initial Each Box  CA-60  DISCIPLINE RECORDS  SPECIAL EDUCATION RECORDS  HEALTH RECORDS  PSYCHOLOGICAL RECORDS  SOCIAL WORK RECORDS
<del></del>
FORWARD RECORDS TO: (circle one)
Summit Academy North Elementary K-5 28697 Sibley Rd, Romulus, MI 48174 734-789-1428 Fax 734-789-1431
Summit Academy North High School 9-12 18601 Middlebelt Romulus, MI 48174 734-955-1730 Fax 734-955-1737
SCHOOL ZONE STATEMENT:
S CURRENTLY ENROLLED IN SUMMIT ACADEMY SCHOOL. IN T 328, PLEASE VERIFY THAT he/she HAS NOT BEEN EXPELLED ATION SUBSEQUENT TO JANUARY 1, 1995. IF THE ABOVE HAS TO A WEAPONS VIOLATION, PLEASE ATTACH AN EXPLANATION STUDENT.
DATE DATE
sion to forward all school records to er enrolled at your school.
Date

# 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 joit 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.

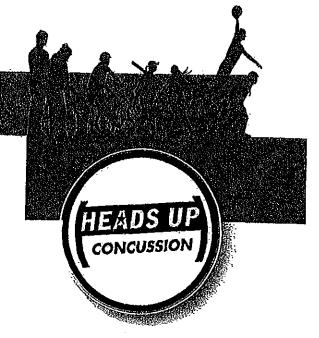


Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports one or more symptoms of concussion after a bump, blow, or loft 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:

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- · 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 clumstly
- · Answers questions slowly
- Loses consciousness (even briefly)
- · Shows mood, beliavlor, or personality changes
- Can't recall events prior to hit or fall-
- Can't recall events after hit or fall





### **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 joil to the head or body s/ne 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
- Sturred speech
- Convulsions or seizures
- · Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- · Has imusual 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 fry 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 sine 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.
- 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.

STUDENT-ATHLETE NAME PRINTED
STUDENT-ATHLETE NAME SIGNED
DATE
PARENT OR GUARDIAN NAME PRINTED
PARENT OR GUARDIAN NAME SIGNED
DATE

JOIN THE CONVERSATION - www.facebook.com/CDCHeadsUp



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).

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