St. Clair Catholic District School Board

Clear Form

ST. CLAIR CATHOLIC DISTRICT SCHOOL BOARD

Student Concussion Diagnosis Report

☐ January 30 ☐ June 28

School: _____

Principal: _____

Student(s) Name(s) Surname Given Name	Date of Birth YYYY/Month/Day	Return to Learn/Return to Physical Activity Plan in Place	Return to Learn/Return to Physical Activity Plan Completed (Y)
1.		☐ YES ☐ NO Date:_____	☐ YES ☐ NO Date:_____
Date/Location of incident:	**Circumstances causing concussion:**		
2.		☐ YES ☐ NO Date:_____	☐ YES ☐ NO Date:_____
Date/Location of incident:	**Circumstances causing concussion:**		
3.		☐ YES ☐ NO Date:_____	☐ YES ☐ NO Date:_____
Date/Location of incident:	**Circumstances causing concussion:**		

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4.		☐ YES ☐ NO Date:_____	☐ YES ☐ NO Date:_____
Date/Location of incident:	**Circumstances causing concussion:**		
5.		☐ YES ☐ NO Date:_____	☐ YES ☐ NO Date;_____
Date/Location of incident:	**Circumstances causing concussion:**		
6.		☐ YES ☐ NO Date_____	☐ YES ☐ NO Date:_____
Date/Location of incident:	**Circumstances causing concussion:**		

Concussion Awareness Training
Staff Completed on (Date): _____
Comments: