St. Clair Catholic
District School Board

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: