Student Name_____ DOB_____ AGE_____
(last) (first) xx-xx-xxxx (year,month)

# St. Mary Preschool

## *New Family Registration Requirements*

Children must be 3 years of age on or before September 1, 2020. Children must be completely potty-trained (out of diapers and pull-ups) and fully independent in the bathroom.

**THE FOLLOWING FORMS MUST BE SUBMITTED AT THE TIME OF REGISTRATION. DAYS WILL NOT BE RESERVED UNTIL ALL PAPERWORK IS FINALIZED.**

- *$100.00 non-refundable deposit*
- *Parent Contract*
- *Child Information Record Health Appraisal Form*
- *Immunization Record*
- *Birth Certificate*
- *Concussion Form (2020-2021)*
- *Photo Release Form (2020-2021)*
- *Baptismal Certificate (if applicable)*
- *Volunteer Background Check Acknowledgement Form (Mother)*
- *Volunteer Background Check Acknowledgement Form (Father)*
- *Receipt of Handbook (will be distributed at Open House)*

## Helpful Tips

**Please be sure to COMPLETE ALL FIELDS on all forms. In the allergy sections please record "none known" or record your child's allergy. "N/A" is not accepted per State of Michigan licensing rules.**

**Health Appraisal**

The Health Appraisal is a physical evaluation, performed within the preceding year, signed by a licensed health care provider. (This must be updated every two years for preschool children 30 months and older).

**Immunization**

Immunization record is a copy of your child's vaccines. You can obtain this from your health care provider. If your child is missing a vaccination or they are overdue for any vaccination, this must be taken care of prior to registration. The alternative is to obtain an immunization waiver.

**Immunization Waiver**

If your child has not been vaccinated, or is overdue or missing any vaccinations that you do not plan on updating, then you must obtain an official waiver from the Livingston County Health Department. This needs to be completed ***prior*** to registration and must be renewed annually. Waiver forms that have not been distributed by the Livingston County Health Department will not be accepted. You must schedule an appointment with the health department, as they do not accept walk-ins. It can take up to a month to get an appointment, so please plan accordingly.

* The Health Appraisal and Immunization Record are separate documents (one does not take place of the other). Each child must have one of each on file.


# ST. MARY PRESCHOOL
# TUITION RATES
# 2020-2021

## Morning Friends Ages 3 & 4

**8:20 AM – 11:15 AM**

| $1170.00 | $1530.00 | $1980.00 | $2430.00 |
|---|---|---|---|
| 2 Days | 3 Days | 4 Days | 5 Days |

## School Day Friends

**8:20 AM – 3:15 PM**

| $2250.00 | $3330.00 | $4410.00 | $4950.00 |
|---|---|---|---|
| 2 Days | 3 Days | 4 Days | 5 Days |

## All Day Friends
## With AM/PM Latchkey

**6:45 AM – 6:00 PM**

| $2970.00 | $4410.00 | $5850.00 | $6570.00 |
|---|---|---|---|
| 2 Days | 3 Days | 4 Days | 5 Days |

**$100.00 Non-Refundable deposit is due at registration. All preschool paperwork including child's birth certificate, physical form and current immunization record MUST be turned into the school office for the registration to be completed.**

**CHILD MUST BE FULLY TOILET TRAINED (out of diapers or pull-ups) and independent to use the bathroom.**

# ST. MARY PRESCHOOL
# FAMILY REGISTRATION/TUITION CONTRACT 2020-2021

**FAMILY INFORMATION: PLEASE PRINT NEATLY**

FAMILY LAST NAME _____

ADDRESS _____ CITY _____ ZIP _____

EMAIL ADDRESS (MOM) _____ (DAD) _____

Tuition is the main source of educational program funding at St. Mary School. Tuition payments are payable to SMART Tuition due the 1st or 15th of each month so that payroll and instructional obligations can be met on time. Payment options are: 1 payment (June), 2 payments (June & Dec.), 4 payments (June, Sept., Dec. & March) and 12 monthly payments (June – May).

Program choice: please the appropriate boxes below

| AM PRESCHOOL | AM PRESCHOOL | AM PRESCHOOL | AM PRESCHOOL | AM PRESCHOOL |
|---|---|---|---|---|
| MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |

| FULL DAY PRESCHOOL | FULL DAY PRESCHOOL | FULL DAY PRESCHOOL | FULL DAY PRESCHOOL | FULL DAY PRESCHOOL |
|---|---|---|---|---|
| MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |

| FULL DAY PRESCHOOL AM/PM LATCHKEY | FULL DAY PRESCHOOL AM/PM LATCHKEY | FULL DAY PRESCHOOL AM/PM LATCHKEY | FULL DAY PRESCHOOL AM/PM LATCHKEY | FULL DAY PRESCHOOL AM/PM LATCHKEY |
|---|---|---|---|---|
| MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY |

**Registration Deposit: $100.00 per child (non-refundable)**

The tuition has been calculated considering a school calendar year. Days off due to vacation days, sick days, and any "Act of God" days do not change the monthly payment. If you remove your child after a quarter begins (4 quarters in school year) you are responsible for payment through that quarter.

Parent /Guardian Signature_____ Date _____

I agree to accept the policies, rules and regulations of St. Mary School as well as all terms contained in this contract and the payment schedule set forth herein.

# SMART TUITION GENERAL ENROLLMENT INSTRUCTIONS

St. Mary School has partnered with Smart Tuition to service your child's tuition account. To enroll online, please follow the instructions below:

**1. ONLINE ENROLLMENT**
Visit: www.enrollwithsmart.com

**1. WELCOME TO ENROLL WITH SMART**
Click on the blue box, Create a New Account.

**2. FIND YOUR SCHOOL**
Enter your school's name in the search box or use school ID# 11536. Make your selection by clicking the green circle.

**3. SECTION 1 – WHO WILL PAY?**
Enter the parent, guardian, or bill payer's contact information. Please provide your telephone number and email address as Smart Tuition regularly communicates important information about your account via telephone and email.

**4. SECTION 2 – WHO WILL ATTEND?**
Enter the names and grades of the children who will attend the school. If you already have a child in this school with a Smart Tuition account, simply add any additional children to your existing account by going to enrollwithsmart.com and enter your current account information under I Have A Smart Account.

**5. SECTION 3 – HOW & WHEN TO PAY?**
Review the payment plans offered by your school and choose one. The payment plans listed are selected by your school and cannot be changed by Smart Tuition. Select your preferred payment method and due date from the options offered by your school.

**6. SECTION 4 – SUBMIT**
Review Smart Tuition's terms and conditions. Click SUBMIT ENROLLMENT to complete your online enrollment.

**REGISTRATION APPLICATION SUCCESSFUL**
You will receive a confirmation page with your Smart Tuition Family ID. Your school will then review your enrollment, and once complete, you will receive confirmation from Smart Tuition.

**ACCOUNT ACTIVATION**
Once your school has reviewed and activated your account, you will receive an email with login instructions.

To view your balance, make payments, update your personal information, or chat with a live representative, access your Smart Tuition account at parent.smarttuition.com.

The Smart Tuition program manages tuition payments and follows the policies established at the school. Decisions regarding tuition amounts, tuition aid, scholarships, and all other tuition related items are made by your school.

We look forward to working with you and your family this year! Our Parent Contact Center is available 24 hours per day. Families can access their accounts to check balances and make payments. Call us at (888) 868-8828.

SMART TUITION™

# CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply, "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

| For Provider Use Only: | Date of Admission | Date of Discharge |
|---|---|---|
| | | |

| Name of Child (Last, First, Middle Initial) | | | Child's Date of Birth |
|---|---|---|---|
| | | | |
| Address (Number and Street, Building/Apartment Number) | City | State | Zip Code |
| | | | |

| Parent/Legal Guardian's Name | Home Phone ( ) | Parent/Legal Guardian's Name (Optional) | Home Phone ( ) |
|---|---|---|---|
| | | | |
| Home Address (if not child's address) | Cell Phone ( ) | Home Address (if not child's address) | Cell Phone ( ) |
| | | | |
| City / State | Zip Code | City / State | Zip Code |
| | | | |
| Email Address (optional) | | Email Address | |
| | | | |
| Employer Name | Work Phone ( ) | Employer Name | Work Phone ( ) |
| | | | |

| Name of Child's Physician or Health Clinic | Physician's or Health Clinic's Phone Number ( ) |
|---|---|
| | |

Hospital Preferred for Emergency Treatment (optional)

Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)

BCAL-3731 (Rev. 7-18) Previous edition 6-17 may be used.

See Reverse Side

**Emergency Contact & Release of Child:** List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

| | | |
|---|---|---|
| 1. | ( ) | ( ) |
| 2. | ( ) | ( ) |
| 3. | ( ) | ( ) |

**Release of Child Only:** List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

| | | | |
|---|---|---|---|
| 1. | ( ) | 2. | ( ) |
| 3. | ( ) | 4. | ( ) |

**Parent/Legal Guardian Initials:**

_____I give permission to _____, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical treatment for the above named minor child while in care.

**I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.**

Signature of Parent or Guardian — Date Signed

| Date Card Reviewed | Parent or Legal Guardian Initials | Date Card Reviewed | Parent or Legal Guardian Initials | Date Card Reviewed | Parent or Legal Guardian Initials | Date Card Reviewed | Parent or Legal Guardian Initials |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

LARA is an equal opportunity employer/program.

AUTHORITY: 1973 PA 116
COMPLETION: Required
PENALTY: Rule Violation Citation.

BCAL-3731 (Rev. 7-18) Previous edition 6-17may be used.

# 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 I. Section III 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.**)

## PERSONAL

| CHILD'S NAME (Last, First, Middle) | | | DATE OF BIRTH (mm/dd/yy) / / |
|---|---|---|---|
| ADDRESS (Number & Street) | (City) | (ZIP Code) MI | TODAY'S DATE (mm/dd/yy) / / |
| PARENT/GUARDIAN (Last, First, Middle) | | | HOME TELEPHONE NUMBER ( ) |
| ADDRESS (Number & Street) | (City) | (ZIP Code) MI | WORK TELEPHONE NUMBER ( ) |

## SECTION I - HEALTH HISTORY

| Yes | No | Resolved | # Is your child having any of the problems listed below? |
|---|---|---|---|
| ☐ | ☐ | ☐ | 1 Allergies or Reactions (for example, food, medication or other) |
| ☐ | ☐ | ☐ | 2 Hay Fever, Asthma, or Wheezing |
| ☐ | ☐ | ☐ | 3 Eczema or Frequent Skin Rashes |
| ☐ | ☐ | ☐ | 4 Convulsions/Seizures |
| ☐ | ☐ | ☐ | 5 Heart Trouble |
| ☐ | ☐ | ☐ | 6 Diabetes |
| ☐ | ☐ | ☐ | 7 Frequent Colds, Sore Throats, Earaches (4 or more per year) |
| ☐ | ☐ | ☐ | 8 Trouble with Passing Urine or Bowel Movements |
| ☐ | ☐ | ☐ | 9 Shortness of Breath |
| ☐ | ☐ | ☐ | 10 Speech Problems |
| ☐ | ☐ | ☐ | 11 Menstrual Problems |
| ☐ | ☐ | ☐ | 12 Dental Problems: Date of Last Exam / / |
| ☐ | ☐ | ☐ | Other (please describe): _____ |
| ☐ | ☐ | | Does your child take any medication(s) regularly? |

Reason for Medication

_____ / /
***Parent/Guardian Signature*** Date

**Birth History:**

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

If yes, list medications:

Was the health history reviewed by a health professional?
☐ Yes ☐ No ***Examiner's Initials:*** _____

## SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

### Tests and Measurements

| No | Yes | Was child tested for: | Test results: | Normal | Referred | Under Care |
|---|---|---|---|---|---|---|
| ☐ | ☐ | VISION | Visual Acuity | | | |
| | | | Muscle Imbalance | | | |
| | | Date: / / | Other: | | | |
| ☐ | ☐ | HEARING | Audiometer | | | |
| | | | Other: | | | |
| | | Date: / / | | | | |
| ☐ | ☐ | URINALYSIS | Sugar | | | |
| | | | Albumin | | | |
| | | Date: / / | Microscopic | | | |
| ☐ | ☐ | BLOOD LEAD LEVEL | Level _____ ug/dl ⇨ | | | |
| | | Date: / / | | | | |

| No | Yes | Was child tested for: | Test results: | Normal | Referred | Under Care |
|---|---|---|---|---|---|---|
| ☐ | ☐ | HEIGHT & WEIGHT | Height | | | |
| | | | Weight | | | |
| | | Other: _____ | Other | | | |
| ☐ | ☐ | HEMOGLOBIN / HEMATOCRIT | ⇨ | | | |
| ☐ | ☐ | BLOOD PRESSURE | Reading: _____ | | | |
| ☐ | ☐ | TUBERCULIN | Type: _____ | | | |
| | | Date: / / | Neg.: ☐ Pos.: ☐ _____ mm | | | |

**NOTE:** Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.

### Examinations and/or Inspections

Essential Findings Deviating from Normal:

Exam Date: / /

## SECTION III - IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*

| VACCINES (Circle Type) | DATE ADMINISTERED MM/DD/YYYY | |
|---|---|---|
| Hepatitis B (HepB) | 1 | 3 |
| | 2 | |
| DTaP/DTP/DT/Td | 1 | 4 |
| | 2 | 5 |
| | 3 | 6 |
| Tdap | 1 | |
| *Haemophilus Influenzae* type b (HIB) | 1 | 3 |
| | 2 | 4 |
| Polio (IPV/OPV) | 1 | 3 |
| | 2 | 4 |
| Pneumococcal Conjugate (PCV7/PCV13) | 1 | 3 |
| | 2 | 4 |
| Rotavirus (RV1/RV5) | 1 | 3 |
| | 2 | |
| Measles,Mumps, Rubella (MMR) | 1 | 2 |
| Varicella (Chickenpox) | 1 | 2 |

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

| VACCINES (Circle Type) | DATE ADMINISTERED MM/DD/YYYY | |
|---|---|---|
| Hepatitis A (HepA) | 1 | 2 |
| Influenza (IIV/LAIV) | 1 | 3 |
| | 2 | 4 |
| Meningococcal (MCV4 / MPSV4) | 1 | 2 |
| Human Papillomavirus (HPV9/HPV4/HPV2) | 1 | 3 |
| | 2 | |
| | Type of Vaccine(s) | Date of Vaccine(s) |
| OTHER Vaccines Specify Date & Type | 1 | |
| | 2 | |
| | 3 | |

*Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable*

*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your provider office for medical waiver forms and through your local health department for nonmedical waiver forms.

Parent/Guardian refused immunizations: ☐

I certify that the immunization dates are true to the best of my knowledge

_____ *Health Professional's Signature* | _____ Title | ___/___/___ Date

## SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

| No | Yes | |
|---|---|---|
| ☐ | ☐ | Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain: |
| ☐ | ☐ | Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other |

Other Recommendations

## SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____ 's teeth. As a result of this examination, my recommendation for treatment is: _____
child's name

_____ *Dentist's Signature* | ___/___/___ Date

## PHYSICIAN'S SIGNATURE

_____ *Examiner's Signature* | ___/___/___ Date | _____ *Examiner's Name (Print or Type)* | _____ Degree or License

_____ Number & Street | _____ City | MI | _____ ZIP Code | (_____) _____ Telephone

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 Department of Health and Human Services, Education, 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.

# PHOTO RELEASE

_____ Yes, I hereby grant St. Mary Catholic School, their legal representative, or those for whom they are acting, the absolute right and permission to copyright and use photographic portraits or pictures of my child for display during the **2020/2021** school year. Photos may be used for marketing purposes such as in the church bulletin, displays, diocesan or school websites, FAITH magazine, etc.

I hereby waive any right I may have to inspect or approve the finished product or products.

I hereby release St. Mary Catholic School, their representative, or those for whom they are acting, from any liability for any violation of any personal or proprietary right I may have in connection with the use of the above stated images.

I state further that I have the above authorization, release and agreement and that I am fully familiar with its contents.

---

_____ No, I decline to have my child's photograph displayed; however, I do allow my child to be in unidentified group pictures with no names mentioned, such as pictures displayed for Catholic Schools Week.

Printed Name of Child: _____ Grade _____

Printed Name of Parent or Guardian: _____

Street Address: _____

City: _____ State _____ Zip Code: _____

Phone: _____

Signature of Parent or Guardian: _____ Date: _____

St. Mary Catholic School
1-10-20

# VOLUNTEER BACKGROUND CHECK

## Acknowledgment Form

*Nonemployment Background Checks Only*

Service to provide: ST. MARY SCHOOL Date to Provide Service: 2020-2021

In order to ensure the protection of children in the care of St. Mary Catholic School, school policy requires, prior to any and all persons providing a volunteer service at the school or for any function conducted by the school; all potential volunteers complete a State of Michigan ICHAT background check. If ICHAT, the background check is a name check only, through the State of Michigan ICHAT system, and is based on individual identifiers. Any applicant declining to complete a "Volunteer Background Check" acknowledgment form will not be considered.

POTENTIAL VOLUNTEER INFORMATION

Full Printed Name: _____

Maiden name or other name(s) previously used: _____

DOB: _____ Sex: _____ Eye Color: _____ Hair Color: _____ Height: _____
[mm/dd/yyyy]

HISTORY INFORMATION

**1)** Have you volunteered at St. Mary Cathloic School before? ☐ Yes ☐ No

**2)** Have you ever pled guilty, or been convicted of a felony in a state or federal court?
☐ Yes ☐ No
Date and state offense/conviction occurred: _____

If yes, provide a detailed description of the conviction: _____

_____

**3)** Have you ever pled guilty, or been convicted of a misdemeanor in a state or federal court?
☐ Yes ☐ No
Date and state offense/misdemeanor occurred: _____

If yes, provide a detailed description of the conviction: _____

_____

**4)** Are you the subject of a current criminal investigation or have pending charges against you?
☐ Yes ☐ No
Date and state the investigation is ongoing: _____

If yes, provide a detailed descripition of the investigation or pending charges: _____

_____

St. Mary Catholic School
1-10-20

St. Mary Cathloic School reserves the right to "approve" or "deny" any volunteer service upon review of the background check returned. The determination will be based upon the individual's fitness to have responsibility for the safety and wellbeing of children. Providing false information, or information contradicting to the background check information, is grounds for immediate volunteer denial.

By affixing your signature to this form you acknowledge your statements are to be true and give full consent to complete the requested background check.

Signature: _____

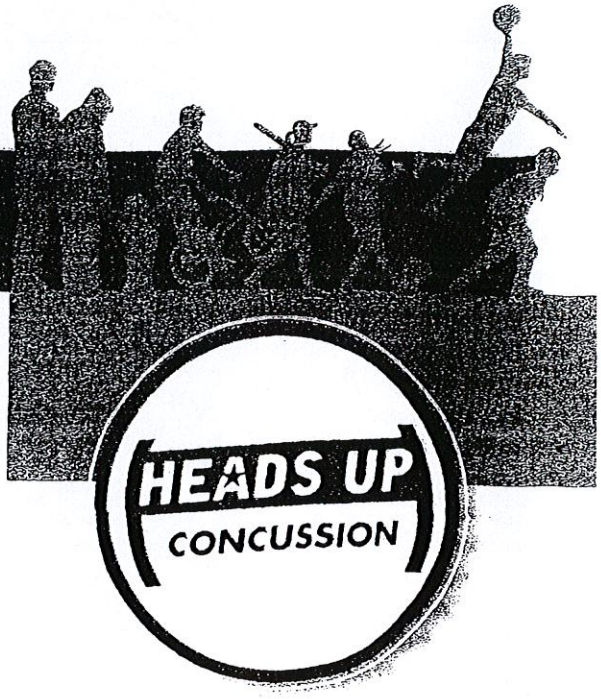
Date Signed: _____

Please return completed form to St. Mary Catholic School/Veronica Kinsey. Questions or concerns, please contact Veronica Kinsey- Principal: mrskinsey@stmarypinckney.org.

OFFICE USE ONLY

Approved ☐ Denied ☐ Date Approved/Denied _____ Determining Staff Member (initials) _____

# 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 jolt 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.

## WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

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 jolt 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:

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

MDHHS
Michigan Department of Health & Human Services

**"IT'S BETTER T MISS ONE GAME THAN THE WHOL SEASON"**

## 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 jolt to the head or body s/he 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
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual 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 try 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 s/he 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.
3. 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 concussi 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

HEADS UP

TO LEARN MORE GO TO

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).