Lostant Community Unit School District 425

Registration Form

1. Student First, Middle, Last Name _____

   Birthdate _____ Birthplace _____ Gender _____ Grade _____

   Ethnicity ___American Indian ___Asian ___Black/African American ___Hispanic ___Multiracial ___Native Hawaiian ___White

2. Student First, Middle, Last Name _____

   Birthdate _____ Birthplace _____ Gender _____ Grade _____

   Ethnicity ___American Indian ___Asian ___Black/African American ___Hispanic ___Multiracial ___Native Hawaiian ___White

3. Student First, Middle, Last Name _____

   Birthdate _____ Birthplace _____ Gender _____ Grade _____

   Ethnicity ___American Indian ___Asian ___Black/African American ___Hispanic ___Multiracial ___Native Hawaiian ___White

4. Student First, Middle, Last Name _____

   Birthdate _____ Birthplace _____ Gender _____ Grade _____

   Ethnicity ___American Indian ___Asian ___Black/African American ___Hispanic ___Multiracial ___Native Hawaiian ___White

Student(s) Live(s) With

___Both Parents ___Mother ___Father ___Other (please list) _____

Father's Name _____

Father's Address _____
Street or P.O. Box City State Zip

Father's Employer & Telephone _____

Father's Telephone Numbers _____

Father's E-mail Address _____

Mother's Name _____

Mother's Address _____
Street or P.O. Box City State Zip

Mother's Employer & Telephone _____

Mother's Telephone Numbers _____

Mother's E-mail Address _____

Emergency Contact People
Name
Relationship
Telephone
Name
Relationship
Telephone

Names and Ages of Other Children Living with Family	
Name	Age
Name	Age
Name	Age
Name	Age
Name	Age
Name	Age

Family Physician _____ Telephone _____

Hospital Preference _____

Known health problems that the school should be made aware of: _____

_____

In case of accident or serious illness, I request the school to contact me. If unable to contact me, I authorize the school to call the physician listed and follow instructions. If unable to contact the physician, the school may make arrangements that seem necessary.

_____ _____

Parent/Guardian Signature Date

Insurance

_____My child is covered by private insurance.

_____My child is participating in the Kid Care program. The number is _____.

_____My child is not covered by any insurance.

Military Families (Optional)

_____The student(s) listed on this form have a parent or guardian who is a member of a branch of the armed forces of the United States who is either deployed to active duty or expects to be deployed to active duty during the school year.

_____ _____

Parent/Guardian Signature Date

Contact Numbers

Please list below ALL telephone numbers you would like on the Phone Blast System with regard to changes in bus routes, school cancellations, and school emergencies.

Student(s) _____

Name	Phone number
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

State of Illinois
Certificate of Child Health Examination

FOR USE IN LICENSED CHILD CARE FACILITIES
CFS 609
Rev 2/2013

IDCFS 609

Student's Name (Last, First, Middle)	Birth Date (Month/Day/Year)	Sex	Race/Ethnicity	School/Grade Level/ID#
Address (Street, City, Zip Code)	Parent/Guardian	Telephone # Home		Work

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or DTaP						
Tdap, Td or Pediatric DT (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)						
MMR Combined Measles Mumps, Rubella						
Single Antigen Vaccines	Measles	Rubella	Mumps			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

COMMENTS:

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature _____ Title _____ Date _____

Signature _____ Title _____ Date _____

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease Signature Title Date

3. Laboratory confirmation (check one) ☐Measles ☐Mumps ☐Rubella ☐Hepatitis B ☐Varicella
Lab Results Date MO DA YR (Attach copy of lab result)

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																						
Age/ Grade																						
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L		
Vision																						
Hearing																						

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

Last	First	Middle	Birth Date Month/Day/Year	Sex	School	Grade Level/ ID

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, Insect, Latex)

Diagnosis of asthma?	Yes	No	
Child wake during night coughing?	Yes	No	
Birth defects?	Yes	No	
Developmental delay?	Yes	No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	
Diabetes?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No	
Seizures? What are they like?	Yes	No	
Heart problem/Shortness of breath?	Yes	No	
Heart murmur/High blood pressure?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No	

Eye/Vision problems? ____ Glasses ☐ Contacts ☐ Last exam by eye doctor ____
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)

Ear/Hearing problems?	Yes	No	
Bone/Joint problem/injury/scoliosis?	Yes	No	

MEDICATION (Include prescription, non-prescription and regular basis)

Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Hospitalizations? When? What for?	Yes	No	
Surgery? (List all.) When? What for?	Yes	No	
Serious injury or illness?	Yes	No	
TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
TB disease (past or present)?	Yes*	No	
Tobacco use (type, frequency)?	Yes	No	
Alcohol/Drug use?	Yes	No	
Family history of sudden death before age 50? (Cause?)	Yes	No	

Dental ☐ Braces ☐ • Bridge ☐ • Plate Other

Information may be shared with appropriate personnel for health and educational purposes.

Parent/Guardian Signature Date

PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA

HEAD CIRCUMFERENCE if < 2-3 years old HEIGHT WEIGHT BMI BP

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes☐ No☐ And any two of the following: Family History Yes ☐ No ☐ Ethnic Minority Yes ☐ No ☐ Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ At Risk Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered ? Yes ☐ No ☐ Blood Test Indicated? Yes ☐ No ☐ Blood Test Date Result

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. No test needed.☐ Test performed ☐

Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm _____

Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value _____

LAB TESTS (Recommended)	Date	Results
Hemoglobin or Hematocrit		
Urinalysis		

	Date	Results
Sickle Cell (when indicated)		
Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs
Skin		
Ears		
Eyes		Amblyopia Yes☐ No☐
Nose		
Throat		
Mouth/Dental		
Cardiovascular/HTN		
Respiratory		☐ Diagnosis of Asthma

	Normal	Comments/Follow-up/Needs
Endocrine		
Gastrointestinal		
Genito-Urinary		LMP
Neurological		
Musculoskeletal		
Spinal Exam		
Nutritional status		
Mental Health		
Other		

Currently Prescribed Asthma Medication:
☐ Quick-relief medication (e.g. Short Acting Beta Agonist)
☐ Controller medication (e.g. inhaled corticosteroid)

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ INTERSCHOLASTIC SPORTS Yes ☐ No ☐ Limited ☐

Print Name (MD,DO, APN, PA) Signature Date

Address Phone

(Complete Both Sides)

Illinois Department of Public Health

Childhood Lead Risk Assessment Questionnaire

ALL CHILDREN 6 MONTHS THROUGH 6 YEARS OF AGE MUST BE ASSESSED FOR LEAD POISONING
(410 ILCS 45/6.2)

Name _____ Today's Date_____

Age _____ Birthdate _____ ZIP Code _____

Respond to the following questions by circling the appropriate answer.	RESPONSE
1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC?	Yes No Don't Know
2. Does this child have a sibling with a blood lead level of10 mcg/dL or higher?	Yes No Don't Know
3. Does this child live in or regularly visit a home built before 1978?	Yes No Don't Know
4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978?	Yes No Don't Know
5. Is this child a refugee or an adoptee from any foreign country?	Yes No Don't Know
6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)?	Yes No Don't Know
7. Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)?	Yes No Don't Know
8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)?	Yes No Don't Know
9. Does this child reside in a high-risk ZIP code area?	Yes No Don't Know

A blood lead test should be performed on children:

- with any "Yes" or "Don't Know" response
- living in a high-risk ZIP code area

All Medicaid-eligible children should have a blood lead test at 12 months of age and at 24 months of age. If a Medicaid-eligible child between 36 months and 72 months of age has not been previously tested, a blood lead test should be performed.

If there is any "Yes" or "Don't Know" response; and

- there has been no change in the child's living conditions; and
- the child has proof of two consecutive blood lead test results (documented below) that are each less than 10 mcg/dL (with one test at age 2 or older), a blood lead test is not needed at this time.

Test 1: Blood Lead Result_____mcg/dL Date _____ Test 2: Blood Lead Result_____mcg/dL Date _____

If responses to all the questions are "NO," re-evaluate at every well child visit or more often if deemed necessary.

_____ _____

Signature of Doctor/Nurse Date

Illinois Lead Program
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: Last	First	Middle	Birth Date: (Month/day/year) / /
Address: Street	City	ZIP Code	Telephone:
Name of School:	Grade Level:		Gender: ☐ Male ☐ Female
Parent or Guardian:	Address (of parent/guardian):		

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note _____

Signature of Dentist _____ Date of Exam _____

Address _____ Telephone _____
Street City ZIP Code

State of Illinois
Department of Public Health

DENTAL EXAMINATION WAIVER FORM

Please print:

Student's Name: Last	First	Middle		Birth Date: (Month/Day/Year) / /
Address: Street	City	ZIP Code		Telephone:
Name of School:		Grade Level:		Gender: ☐ Male ☐ Female
Parent or Guardian:		Address (of parent/guardian):		

I am unable to obtain the required dental examination because:

☐ My child is enrolled in the free and reduced lunch program and is not covered by private or public dental insurance (Medicaid/All Kids).

☐ My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/All Kids).

☐ My child is enrolled in Medicaid/All Kids, but we are unable to find a dentist or dental clinic in our community that is able to see my child and will accept Medicaid/All Kids.

☐ My child does not have any type of dental insurance, and there are no low-cost dental clinics in our community that will see my child.

Signature _____ Date _____

State of Illinois
Eye Examination Report

Recommendations

1. Corrective lenses: ☐ No ☐ Yes, glasses or contacts should be worn for:
   ☐ Constant wear ☐ Near vision ☐ Far vision
   ☐ May be removed for physical education

2. Preferential seating recommended. ☐ No ☐ Yes

   Comments _____

3. Recommend re-examination: ☐ 3 months ☐ 6 months ☐ 12 months

   ☐ Other _____

4. _____

5. _____

Print name _____

Optometrist or physician (such as an ophthalmologist) who provided the eye examination ☐ MD ☐ OD ☐ DO

License Number _____

Address _____

_____

Phone _____

Signature _____

Date _____

Consent of Parent or Guardian

I agree to release the above information on my child or ward to appropriate school or health authorities.

_____
(Parent or Guardian's Signature)

_____
(Date)

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Printed by Authority of the State of Illinois
6-09

State of Illinois
Department of Public Health
Eye Examination Waiver Form

Please print:

Student Name _____ (Last) _____ (First) _____ (Middle Initial) Birth Date _____ (Month/Day/Year)

School Name _____ Grade Level _____ Gender ☐ Male ☐ Female

Address _____ (Number) _____ (Street) _____ (City) _____ (ZIP Code)

Phone _____ (Area Code)

Parent or Guardian _____ (Last) _____ (First)

Address of Parent or Guardian _____ (Number) _____ (Street) _____ (City) _____ (ZIP Code)

I am unable to obtain the required vision examination because:

☐ My child is enrolled in medical assistance/ALL KIDS, but we are unable to find a medical doctor who performs eye examinations or an optometrist in the community who is able to examine my child and accepts medical assistance/ALL KIDS.

☐ My child does not have any type of medical or vision/eye care coverage, my child does not qualify for medical assistance/ALL KIDS, there are no low-cost vision/eye clinics in our community that will see my child, and I have exhausted all other means and do not have sufficient income to provide my child with an eye examination.

☐ Other undue burden or a lack of access to an optometrist or to a physician who provides eye examinations: _____

_____

Signature _____ Date _____

(Source: Added at 32 Ill. Reg. _____, effective _____)

Home Language Survey

Dear Parent/Guardian,

The Federal NCLB-Title III Act and the Illinois School Code require that each school district administer a Home Language Survey to every student entering the district's schools for the first time. This information is used to report to the state the number of students whose families speak a language other than English. It also helps to identify the need for English Language Learning services in the schools. Your cooperation in helping us meet this important legal requirement is appreciated.

Student Name _____ Grade _____
School _____ Birthdate _____ Gender _____
Country of Birth _____ Home Phone Number _____

1. Does anyone in your home speak a language other than English? YES NO
If yes, what language? _____

2. Which language is spoken most often in your home? _____
Please be specific. (example: Mandarin, not Chinese)

3. Does this student speak a language other than English? YES NO
Note: Foreign languages the student has learned in school do not count.

If the answer is NO, go to question # 7. If the answer is YES, please continue.

What language, other than English, does this student speak? _____

Can the student read this language? YES NO

Can the student write this language? YES NO

4. Does this student ……

…understand English? YES NO … speak English? YES NO

…read English? YES NO … write in English? YES NO

5. Which language does this student speak most often with his/her parents? _____

6. Which language does this student speak most often with his/her friends? _____

7. Where did this student attend school last year? _____

8. Was this student in a bilingual or ELL/ESL program during the last school year? YES NO

9. Was this student ever in a Bilingual or ELL/ESL program? YES NO

If yes, what grade(s)? _____ where (school/city)? _____

10. If you speak a language other than English, would you be willing to occasionally translate at school if needed? YES NO

Revised January 2009

_____ _____
Parent/Guardian Signature Date

OFFICE USE ONLY

Home & Other Language on student's language record will match language(s) listed in question 1.
If more than one language is listed, the first language listed shall be HOME, and the second shall be OTHER on the student's language record.

Pre-participation Examination

PHYSICAL EXAMINATION FORM

Name _____
Last First M.I.

EXAMINATION			
Height Weight ☐ Male ☐ Female			
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N			
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart [b] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only)[c]			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic [c]			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/Ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

[b] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam
[c] Consider GU exam if in private setting. Having third party present is recommended
[c] Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for 395 days from this date.

Yes _____ No _____ Limited _____ Examination Date _____

Additional Comments:

Physician's Signature _____ Physician's Name _____

Physician's Assistant Signature* _____ PA's Name _____

Advanced Nurse Practitioner's Signature* _____ ANP's Name _____

*effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.

Pre-participation Examination

PHYSICAL EXAMINATION FORM

Name_____
Last First M.I.

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/Ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam
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On the basis of the examination on this day, I approve this child's participation in interscholastic sports for 395 days from this date.

Yes No Limited Examination Date

Additional Comments:

Physician's Signature Physician's Name

Physician's Assistant Signature* PA's Name

Advanced Nurse Practitioner's Signature* ANP's Name

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A Fact Sheet for

YOUTH SPORTS PARENTS

HEADS UP CONCUSSION

This sheet has information to help protect your children or teens from concussion or other serious brain injury.

What Is a Concussion?

A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move quickly back and forth. This fast movement can cause the brain to bounce around or twist in the skull, creating chemical changes in the brain and sometimes stretching and damaging the brain cells.

How Can I Help Keep My Children or Teens Safe?

Sports are a great way for children and teens to stay healthy and can help them do well in school. To help lower your children's or teens' chances of getting a concussion or other serious brain injury, you should:

- Help create a culture of safety for the team.
  - Work with their coach to teach ways to lower the chances of getting a concussion.
  - Emphasize the importance of reporting concussions and taking time to recover from one.
  - Ensure that they follow their coach's rules for safety and the rules of the sport.
  - Tell your children or teens that you expect them to practice good sportsmanship at all times.
- When appropriate for the sport or activity, teach your children or teens that they must wear a helmet to lower the chances of the most serious types of brain or head injury. There is no "concussion-proof" helmet. Even with a helmet, it is important for children and teens to avoid hits to the head.

How Can I Spot a Possible Concussion?

Children and teens who show or report one or more of the signs and symptoms listed below—or simply say they just "don't feel right" after a bump, blow, or jolt to the head or body—may have a concussion or other serious brain injury.

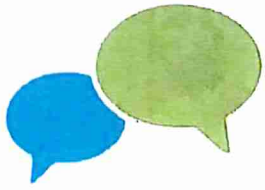
Signs Observed by Parents

- Appears dazed or stunned.
- Forgets an instruction, is confused about an assignment or position, or is unsure of the 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* or *after* a hit or fall.

Symptoms Reported by Children and Teens

- Headache or "pressure" in head.
- Nausea or vomiting.
- Balance problems or dizziness, or double or blurry vision.
- Bothered by light or noise.
- Feeling sluggish, hazy, foggy, or groggy.
- Confusion, or concentration or memory problems.
- Just not "feeling right," or "feeling down."

Talk with your children and teens about concussion. Tell them to report their concussion symptoms to you and their coach right away. Some children and teens think concussions aren't serious or worry that if they report a concussion they will lose their position on the team or look weak. Remind them that *it's better to miss one game than the whole season.*



CDC
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

GOOD TEAMMATES KNOW:
IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON.

Concussions affect each child and teen differently. While most children and teens with a concussion feel better within a couple of weeks, some will have symptoms for months or longer. Talk with your children's or teens' health care provider if their concussion symptoms do not go away or if they get worse after they return to their regular activities.

Plan ahead.

What do you want your child or teen to know about concussion?

What Are Some More Serious Danger Signs to Look Out For?

In rare cases, a dangerous collection of blood (hematoma) may form on the brain after a bump, blow, or jolt to the head or body and can squeeze the brain against the skull. Call 9-1-1 or take your child or teen to the emergency department right away if, after a bump, blow, or jolt to the head or body, he or she has one or more of these danger signs:

- One pupil larger than the other.
- Drowsiness or inability to wake up.
- A headache that gets worse and does not go away.
- Slurred speech, weakness, numbness, or decreased coordination.
- Repeated vomiting or nausea, convulsions or seizures (shaking or twitching).
- Unusual behavior, increased confusion, restlessness, or agitation.
- Loss of consciousness (passed out/knocked out). Even a brief loss of consciousness should be taken seriously.

You can also download the CDC *HEADS UP* app to get concussion information at your fingertips. Just scan the QR code pictured at left with your smartphone.

What Should I Do If My Child or Teen Has a Possible Concussion?

As a parent, if you think your child or teen may have a concussion, you should:

1. Remove your child or teen from play.
2. Keep your child or teen out of play the day of the injury. Your child or teen should be seen by a health care provider and only return to play with permission from a health care provider who is experienced in evaluating for concussion.
3. Ask your child's or teen's health care provider for written instructions on helping your child or teen return to school. You can give the instructions to your child's or teen's school nurse and teacher(s) and return-to-play instructions to the coach and/or athletic trainer.

Do not try to judge the severity of the injury yourself. Only a health care provider should assess a child or teen for a possible concussion. You may not know how serious the concussion is at first, and some symptoms may not show up for hours or days. A child's or teen's return to school and sports should be a gradual process that is carefully managed and monitored by a health care provider.

Children and teens who continue to play while having concussion symptoms or who return to play too soon—while the brain is still healing—have a greater chance of getting another concussion. A repeat concussion that occurs while the brain is still healing from the first injury can be very serious and can affect a child or teen for a lifetime. It can even be fatal.

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CDC
Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

To learn more, go to www.cdc.gov/HEADSUP