THE GROSSE POINTE PUBLIC SCHOOL SYSTEM
389 St. Clair Ave.
Grosse Pointe, MI 48230
313-432-3083 313-432-3031 (fax)
www.gpschools.org

Registration/Enrollment Checklist

Your child is not officially enrolled in Grosse Pointe Public Schools until your residency is verified and you submit the required enrollment documentation.

ALL RESIDENCY AND ENROLLMENT DOCUMENTATION MUST BE PROCESSED AT 389 ST. CLAIR

PAPERWORK WILL NOT BE ACCEPTED AT THE SCHOOL

***Please bring the following documentation with you to your appointment*:**

- ☐ Residency Verification Documentation
  (see website for required documents)
- ☐ Completed Enrollment Packet
  - Enrollment Form
  - Emergency Form
  - Home Language Survey
  - Communication Release Forms
- ☐ Original Birth Certificate*
  - Copies made for CA-60 – original documents returned
- ☐ Immunization Record(s)*/Health Appraisal Form*
  - Copies made for CA-60 – original documents returned
- ☐ Proof of Vision Screening **(Kindergarten only)**
- ☐ Most recent report card/transcript
- ☐ Court Documents (if applicable)
  (Custody Paperwork, Guardianship)

Enrollment Office Hours are:
Monday-Thursday 8am – 4pm / Friday 8am – 3:30pm
No appointment is necessary

Grosse Pointe Public Schools
Early Childhood Enrollment Questionnaire

The following questions are asked so that we can best understand your child. Please fill out this questionnaire before your child is evaluated. Please read the questions carefully and answer them as fully as possible. Please star (*) any questions that you do not understand.

Child's Information

Legal Name_____ Birth Date_____ Sex_____ Age_____

Home Address _____ Home Phone_____

City_____ State_____ Zip Code_____

Parent's Email Address_____

Child's Doctor_____ Dr.'s phone # _____

A. Is child's **ethnicity** Hispanic or Latino? Yes ☐ or No ☐
B. **Race**: American Indian/Alaskan Native ☐
Asian ☐ White ☐ Black/African American ☐
Native Hawaiian/Other Pacific Islander ☐

Both Parts A & B must be completed. We encourage you to select an answer for both parts. If either Part A or B is not answered, the US Department of Education **requires** the school district to supply an answer on your behalf. You may select more than one race designation.

What are the problems that caused you to seek help for your child?

_____

_____

Family History

Child is living with:
☐ Both Parents ☐ Mother ☐ Father ☐ Mother and Stepfather

☐ Father and Stepmother ☐ Legal Guardian ☐ Other (please specify)_____

Is the child adopted? ☐ Yes ☐ No Child's age at adoption_____

Primary language spoken in the home: _____

Status of parents' marriage:
☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

_____ (___)_____ (___)_____ (___)_____
Mother's Name — Home Phone (*if different from above*) — Cell Phone — Work Phone

_____ _____
Place of Employment — Email Address

_____ (___)_____ (___)_____ (___)_____
Father's Name — Home Phone (*if different from above*) — Cell Phone — Work Phone

_____ _____
Place of Employment — Email Address

CONFIDENTIALITY STATEMENT

The information contained in this report is confidential and is protected by Federal Confidentiality Rules (42CFR Part 2) and/or the Family Educational Rights and Privacy Act of 1974 (FERPA). If you are erroneously in possession of this report, you are directed to return it immediately to the Grosse Pointe Public School System, Department of Student Services, 20090 Morningside, Grosse Pointe Woods, MI 48236

Other Children

(including step-siblings and half-siblings)

Name	Age	Sex	School	School/behavioral/health problems?

Biological Extended Family

Do any extended family members (maternal/paternal grandparents, uncles, aunts, cousins) suffer from problems with inattentiveness or hyperactivity; epilepsy; seizures; migraines; alcoholism or substance abuse; psychological, emotional, or personality difficulty; learning problems or developmental disabilities; and/or a "nervous" or neurological disorder; etc.? ☐ Yes ☐ No

If yes, please list relationship to child, disorder, and any treatment received.

Maternal (mother's side)	Paternal (father's side)

Please provide any other information about the child's extended family that might help us understand the child's needs (medical, developmental, behavioral, educational, emotional, or psychological

_____

_____

Birth and Developmental History

Pregnancy

Length in months:_____

Any illnesses or complications while pregnant? ☐ Yes ☐ No

If yes, please explain:_____

Medications taken by the mother **during** pregnancy? _____

Other substances used **during** pregnancy: Cigarettes ☐ Alcohol ☐ Drugs ☐ If yes, please describe type and frequency_____

Was the father taking any medications or drugs at time of conception? Yes ☐ No ☐ If so, what? _____

How many pregnancies and/or miscarriages has the mother had? _____

Labor and Delivery

Where was the child born? _____

Was the birth of the child "normal"? ☐ Yes ☐ No If no, please explain:

_____

_____

Do you think the child's problems might be related to pregnancy, labor, or delivery? ☐ Yes ☐ No
If yes, please explain:

_____

_____

Perinatal History

Birth weight:_____Length: _____APGAR scores (if known):_____

Did mother or baby stay in Special or Intensive Care? ☐ Yes ☐ No Length of baby's stay? _____

Please describe any problems:_____

_____

Please list any birth defects:_____

General Health

Where does your child receive health care?

Physician's Name_____ Phone _____

Address_____

When was your child's last physical examination? _____ Are immunizations up to date? _____

Did any event, health condition, separation, etc., disturb early infant/mother bonding or the developing toddler/mother relationship? ☐ Yes ☐ No If yes, please explain._____

_____

Please describe the child **as an infant** (temperament, sleeping, eating patterns, etc.)._____

_____

Medical History

Has your child been taken to the emergency room with a serious emergency, hospitalized, or had outpatient surgery since birth? ☐ Yes ☐ No
If yes, please describe condition/injury, treatment, any surgery, when, how long, and where? _____

_____

Does your child seem to be able to control his or her behavior and attention? ☐ Yes ☐ No
Please explain:

_____

Has your child ever been diagnosed by a psychologist, physician, or other professional as having a developmental delay, medical or psychological disorder? ☐ Yes ☐ No If yes, when? _____

What treatment has your child had for this? _____

_____

Date of last hearing test:_____ Were the results normal? ☐ Yes ☐ No

Date of last vision test:_____ Does the child wear: ☐ Glasses? ☐ Contacts?

Why?_____

Please list medications (with dosage and times) currently being taken by the child, including nonprescription medications:

_____

_____

As far as you know, does (or did) your child have (please check)

☐allergies ☐eczema ☐anemia ☐asthma ☐frequent ear infections

☐meningitis ☐seizures ☐heart trouble ☐stomach/bowel trouble

The child's current health is: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Infancy and Early Childhood / Developmental History

Motor / Sensory / Play / Speech and Language Milestones

Milestone		Approximate age when achieved (if applicable)	
Reaches for toys	_____	Cruises furniture	_____
Grasps toy	_____	Walks alone	_____
Feeds self with spoon	_____	First word	_____
Drinks from a cup	_____	Points to objects or people	_____
Holds head up alone	_____	Names objects	_____
Rolls over	_____	Says sentences with 2+ words	_____
Creeps/crawls	_____	Runs easily	_____
Sits alone without support	_____	Toilet trained	_____
Pulls self to standing	_____	Make-believe/pretend play	_____

Overall rate of development ☐ Slow ☐ Normal ☐ Fast

Educational/Daycare History

Does your child attend preschool or daycare? If so, list location, type of program, number of days/hours per week, age when started, and progress.

_____

_____

_____

Behavioral and Mental Health History

Please describe any behaviors that are particularly concerning to you or others:_____

_____

_____

Please list any unusual, traumatic, or possibly stressful events in the child's life that you think may have had an impact on his or her development and current functioning. Include incident, child's age at the time, and comments.

_____

_____

Has the child been placed in special education programs currently or in the past? ☐ Yes ☐ No

Category:_____

Additional Information

Please attach results of any previous evaluations/testing, including audiological evaluations.

Please add any additional comments you think might be helpful in assessing your child.

_____

_____

_____

_____

Signature:_____ _____

Individual(s) Completing Form Relationship to Child

Date: _____

THE GROSSE POINTE PUBLIC SCHOOL SYSTEM EMERGENCY INFORMATION/AUTHORIZATION FOR EMERGENCY TREATMENT

STUDENT MAY NOT REGISTER UNLESS THIS FORM IS COMPLETED AND SIGNED BY PARENT/GUARDIAN

Student Last Name | Student First Name | Gender | Date of Birth | Area Code & Phone #

Student Home Address | City | State | Zip | Grade | School

If Parents are divorced: Legal Custody(Mother/Father/Both) | Physical Custody(Mother/Father/Both) | If specific instructions or restrictions apply, attach Court Order/Judgment

Persons to call in the event of an emergency. If we are unable to contact the student's parent/guardian, the other contacts listed may be called and will assume temporary care of the student. Please ensure that information listed below is accurate. Please note: STUDENT WILL NOT BE RELEASED TO PERSONS WITHOUT IDENTIFICATION.

Parent/Guardian Information

Father/Guardian Name | Complete Home Address *(if different from above)* | email address

AC & **Home** Phone # | AC & **Cell** Phone # (1) | AC & **Cell** Phone # (2) | AC & **Work** Phone # (1) | AC & **Work** Phone #(2)

Mother/Guardian Name | Complete Home Address *(if different from above)* | email address

AC & **Home** Phone # | AC & **Cell** Phone # (1) | AC & **Cell** Phone # (2) | AC & **Work** Phone # (1) | AC & **Work** Phone # (2)

Emergency Contact Information

Emergency Contact Name | Relationship | AC & Home Phone# | AC & Cell Phone# | AC & Work Phone#

Emergency Contact Name | Relationship | AC & Home Phone# | AC & Cell Phone# | AC & Work Phone#

Emergency Contact Name | Relationship | AC & Home Phone# | AC & Cell Phone# | AC & Work Phone#

Emergency Contact Name | Relationship | AC & Home Phone# | AC & Cell Phone# | AC & Work Phone#

If your child needs any medications (over the counter or prescription) administered during school time, be sure to fill out *Permission to Administer Medication* Form and speak with school personnel.

Has your child had any serious accidents, illnesses or operations that might limit activity?
☐ No ☐ Yes: .....

Vision problem(s)? ☐ No ☐ Yes:

Allergies:
☐ Medications .....
☐ Food .....
☐ Insects .....
☐ Other .....

Medical Conditions:
☐ Asthma ☐ Diabetes
☐ Blood Abnormality ☐ Neurologic
☐ Cardiac ☐ Other: .....

Does your Child Require any of these items be kept at school?
☐ Asthma Inhaler ☐ Peak Flow Meter
☐ Blood Sugar Test ☐ Other: .....
☐ Epi Pen .....

Physician's Name | Physician's AC & Phone # | Dentist's Name | Dentist's AC & Phone #

School Insurance? ☐ No ☐ Yes

Medical/Hospital Insurance Co | Subscriber's Name | Contract # | Group # | Service Code

I/We the parent or legal guardian of the above named student at Grosse Pointe Public Schools hereby delegate to any teacher or administrator of the Grosse Pointe Public School System who has responsibility of supervising him/her, the authority to authorize and consent to any and all emergency medical, surgical, dental or hospital care or treatment while he/she is a student at school and/or on an educational field trip. Such treatment is to be rendered by, or under the supervision of, a licensed physician or dentist. Such teacher or administrator is fully authorized to act in accordance with his/her judgment in any such emergency and is absolved from any liability or financial responsibility to connection therewith.
Your signature below indicates that the information on this form is correct. If the school is unable to contact a parent or guardian, we are authorized to release your child to the emergency contact listed. In case of a medical emergency at school, the parent, guardian or designee listed on this form is required to meet and transport the student home. When judged necessary, an EMS may be called and may transport the student to a local hospital. (The local government may charge a fee for ambulance service; **if required in an emergency, you may be charged. Grosse Pointe Public Schools will not be responsible for such charges.**)

Signature of Parent/Guardian_____

Signature of Parent/Guardian_____

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 Exzema 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			

Birth History:

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

If yes, please describe:

If yes, list medications:

_____ / /

Parent/Guardian Signature Date

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 (Hep B)	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 Cickenpox Disease? ☐ Yes ☐ No If yes, date:

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (Hep A)	1	2
Influenza TIV/LAIV	1	3
	2	4
Meningococcal MCV4 / MPSV4	1	2
Human Papillomavirus (HVP4/HPV2)	1	2
	2	3
	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 child's school or local health department.

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

_____ _____ MI _____ (___) _____

Number & Street City 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 schedule of well-child care 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 and regular intervals based on age.

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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.

Grosse Pointe Public School System

Home Language Survey

Federal and State laws require the following information be collected about the primary and home language of every student upon enrollment in the school district. Please complete a survey for each child you are enrolling in the school district.

Student Name: _____

Birth Date: _____ Gender: Male _____ Female _____

Parent/Guardian Name: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

School: _____ Grade: _____

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1. Is the student's native language English? ☐ YES ☐ No

   If not, what is the language? _____

2. Is a language other than English spoken in the student's home or environment? ☐ YES ☐ No

   If so, what is the language? _____

_____ _____

Parent or Guardian's Signature Date

Please note: This form has two sections

Part A: JRB-R-4 (FERPA) PUBLIC USE-DIRECTORY INFORMATION NOTICE

The Family Educational Rights and Privacy Act requires that the School System give public notice to parents about student information it considers "directory information." Directory information, which the school system may choose to release (but is not required to release), may include the following: student name, address, telephone number, picture, parent or guardian, date, place of birth, major field of study, weight, height, participation in and eligibility for officially recognized activities and sports, dates of school attendance or grade placement, honors and awards received, and the most recent educational agency or school attended by the student. (Please note: the school system itself may access home telephone numbers for rapid contact in case of emergency school closing, but this use does not constitute public distribution.) More information about the Family Educational Rights and Privacy Act is available at http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html

Note: Individual schools and/or parent groups typically publish names and addresses in an annual directory of school families. These public school directories are NOT part of the FERPA law. Individual schools will request separate permission for this information.

Periodically the Grosse Pointe Public School System releases directory information to outside agencies that include, but are not limited to, school PTO groups, Josten's Class Rings and branches of the military. If you do not want to have FERPA directory information made available, you may have it excluded from release by checking the appropriate box.

☐ I do **not** want **any** FERPA directory information about my child disclosed. (This also includes denial of access of information to any branch of the US Military.)

Part B: Permission for Publishing on Grosse Pointe Public School Web Pages

As of September, 2003, the district requires that children and parents of minors grant permission – through a signed release-for the school or district to display students' first names (only), photos, or work on district web sites.

What CAN be published when permission is granted:

- Student's first name without picture on the same Web page.
- Student's picture without first name on the same Web page.
- Student's work with first name (no picture) on the same Web page.

☐ **I DO NOT GIVE** the Grosse Pointe Public School System permission to use my child's first name, photograph, and/or work on a district Web page.

☐ I give the Grosse Pointe Public School System permission to use my child's first name, photograph and/or work on a district Web page. The material will be used only for school-related activities. First names and photographs will not be used together on the same page.

Student's Printed Name: ____School:________________

Parent/Guardian's Printed Name: ____

Parent's Signature: ____Date: ______________

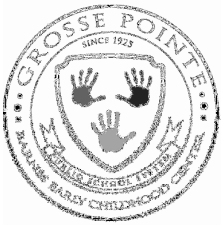
Parent/Guardian Signature Required if student is under 18.

Return completed forms to school office during 1st week of school

- -

Office Use Only- Restricted Information Data

1 - No Directory only   2 - No Web only   3 - No Directory & No Web



PARENTAL PERMISSION FOR A STUDENT TO APPEAR IN A PHOTOGRAPH AND/OR VIDEO

The signature below indicates my approval for my child to appear in a photograph and/or video taken for Grosse Pointe School System purposes only.

Photographs: ☐ YES ☐ NO

Videos: ☐ YES ☐ NO

_____ _____

Student's Name School

_____ _____

Parent/Guardian Signature Date

Educational Material for Parents and Students (Content Meets MDCH Requirements)

Sources: Michigan Department of Community Health. CDC and the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

UNDERSTANDING CONCUSSION

Some Common Symptoms

Headache	**Balance Problems**	**Sensitive to Noise**	**Poor Concentration**	**Not "Feeling Right"**
Pressure in the Head	**Double Vision**	**Sluggishness**	**Memory Problems**	**Feeling Irritable**
Nausea/Vomiting	**Blurry Vision**	**Haziness**	**Confusion**	**Slow Reaction Time**
Dizziness	**Sensitive to Light**	**Fogginess**	**"Feeling Down"**	**Sleep Problems**
		Grogginess		

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 fall, bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. A concussion can be caused by a shaking, spinning or a sudden stopping and starting of the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious. A concussion can happen even if you haven't been knocked out.

You can't see a concussion. Signs and symptoms of concussions can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the student reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away. A student who may have had a concussion should not return to play on the day of the injury and until a health care professional says they are okay to return to play.

IF YOU SUSPECT A CONCUSSION:

1. **SEEK MEDICAL ATTENTION RIGHT AWAY –** A health care professional will be able to decide how serious the concussion is and when it is safe for the student to return to regular activities, including sports. Don't hide it, report it. Ignoring symptoms and trying to "tough it out" often makes it worse.

2. **KEEP YOUR STUDENT OUT OF PLAY –** Concussions take time to heal. Don't let the student return to play the day of injury and until a heath care professional says it's okay. A student who returns to play too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the student for a lifetime. They can be fatal. It is better to miss one game than the whole season.

3. **TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION –** Schools should know if a student had a previous concussion. A student's school may not know about a concussion received in another sport or activity unless you notify them.

SIGNS OBSERVED BY PARENTS:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Can't recall events prior to or after a hit or fall
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes

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. A student 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/places
- Becomes increasingly confused, restless or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously.)

HOW TO RESPOND TO A REPORT OF A CONCUSSION:

If a student reports one or more symptoms of a concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of athletic play the day of the injury. The student should only return to play with permission from a health care professional experienced in evaluating for concussion. During recovery, rest is key. Exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse. Students who return to school after a concussion may need to spend fewer hours at school, take rests breaks, be given extra help and time, spend less time reading, writing or on a computer. After a concussion, returning to sports and school is a gradual process that should be monitored by a health care professional.

Remember: Concussion affects people differently. While most students 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.

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

Parents and Students Must Sign and Return the Educational Material Acknowledgement Form

CONCUSSION AWARENESS

EDUCATIONAL MATERIAL ACKNOWLEDGEMENT FORM

By my name and signature below, I acknowledge in accordance with Public Acts 342 and 343 of 2012 that I have received and reviewed the Concussion Fact Sheet for Parents and/or the Concussion Fact Sheet for Students provided by _____
Sponsoring Organization

_____	_____
Participant Name Printed	Parent or Guardian Name Printed
_____	_____
Participant Name Signature	Parent or Guardian Name Printed
_____	_____
Date	Date

Return this signed form to the sponsoring organization that must keep on file for the duration of participation or age 18.

Participants and parents please review and keep the educational materials available for future reference.