FARNBOROUGH HILL

WHOLEHEARTEDLY

HEALTH CARE AND FIRST AID POLICY

(including Administration of Medicines Policy)

Our Mission

Farnborough Hill welcomes all into our community, where we aim to live Christ's Gospel values joyfully and wholeheartedly, forming each individual to fulfil her potential and face the future with wisdom, strength and dignity.

Farnborough Hill aims to provide a level of Health Care and First Aid cover that ensures a competent and swift response to illness or accident suffered by a pupil, or member of staff, or visitor whilst in school, or when engaged on a school activity out of school.

This policy should be read in conjunction with the following:

- Administration of Medicines Policy (Annex 1 of this policy)
- Educational Visits Policy
- Mental Health Policy
- Safeguarding and Child Protection Policy
- School Counselling Policy
- Supporting Pupils with Medical Conditions Policy

School Nurse

The School's medical area is in St Raphael's on the second floor of the Old House. This area includes the Rennie Surgery. It is staffed by a School Nurse (a qualified registered nurse), who is responsible for the health care of pupils while in school. The School Nurse is on duty in the Rennie Surgery, usually from 9.00 am to 4.00 pm every school day, and she is available to administer First Aid, to deal with any accidents or emergencies or to help if someone is taken ill during school hours as well as supporting those pupils with long-term medical conditions. The Rennie Surgery should not be used for the purpose of seeking medical advice for ongoing medical issues unless previously agreed with the School Nurse. These types of issues should be raised by pupils or parents with their GP.

There are also a number of members of the teaching and support staff who are trained as First Aiders, and they are capable of giving First Aid if a pupil is injured, for example during sport or if the School Nurse is dealing with another issue. Where at all possible, at least one qualified first aider is on school site when children are present. A list of members of staff trained in First Aid and in the management of anaphylaxis, including the use of an auto-injector such as an EpiPen, is posted in the staffroom and on Firefly, and also held by the School Office. It can also be found in Annex 2 below.

Pupils feeling unwell

A pupil feeling unwell should inform their teacher if this occurs during a lesson. The class teacher will then refer them to the Rennie Surgery as appropriate. Outside of lesson times the pupil should report to the Rennie Surgery during Surgery hours (break and lunchtime), accompanied if appropriate by a fellow pupil or member of staff. The School Nurse (or School Office/First Aider) will assess the pupil's condition and decide on the appropriate course of action. During the school day the School Nurse will care for an unwell pupil in the Rennie Surgery or telephone the pupil's parents to arrange collection. If a pupil feels unwell outside of lesson hours and also Surgery hours, they should inform the member of staff who is supervising them at the time (as part of a co-curricular activity or Prep) or go to the School Office. No pupil should contact their parents

independently in order to arrange to be picked up if they are feeling unwell. This decision must be made by the School Nurse or other appropriate member of staff.

Contact with parents

The School will contact parents if:

- a pupil suffers anything more than a minor injury or period of feeling unwell,
- if there are any concerns about the pupil or
- if it is deemed appropriate by the School Nurse.

Minor injuries or mild ailments that are treated at the School will not be routinely communicated to parents, but will be documented on the pupil's medical record.

In the event that a pupil requires hospital treatment, the School Nurse will contact parents to discuss the matter and make further arrangements. In most cases where emergency treatment is not required, parents will be asked to collect their daughter and take her to hospital themselves. If it is not possible to contact parents, or they are unable to attend, a member of staff will take the pupil to hospital and then wait until their parents attend. If there is an emergency, an ambulance will be called immediately by the School Nurse/First Aider. A staff member will then accompany the pupil to hospital and wait until their parents attend.

Medical Questionnaire

At the time of entry to the School, parents are required to complete a confidential Medical Form (e-form) giving a full medical history for their daughter. Details from these forms are uploaded to a pupil's health record on iSAMS, along with any records of visits to the School Nurse. These records are confidential. Parents should notify the School Nurse of any and all additions that should be made to the Medical Record during the pupil's time at school, ensuring that it is kept up-to-date. An annual request for this update will be made before the commencement of each school year. Information about medical diagnoses (either at the time of entry to the School or as part of a medical update) should be accompanied by a formal written diagnosis at consultant level. This can be a consultant letter following a clinic appointment, as long as it contains the formally stated diagnosis.

Medicines and treatments brought to school by pupils

Parents are asked to inform the School Nurse, and complete a medication consent form, about any medication that a pupil brings into school. Unless there is an exceptional reason which has been formally agreed by the School Nurse, no pupil should carry medication on their person or self-medicate while at school, even medication for minor ailments, such as Paracetamol. If a pupil has a medical condition which necessitates regular access to medication, parents are asked to inform the School Nurse so that an appropriate regime can be put in place. The relevant academic and pastoral staff will be informed, in confidence, of any condition that is likely to affect the pupil in any area of school life. The Medication in School consent form can be downloaded from the school website.

Emergency medical treatment

In accepting a place at the School, parents are required to authorise the Headmistress (or an authorised deputy acting on her behalf) to consent, on the advice of an appropriately qualified medical specialist, to their child receiving emergency medical treatment if the School has been unable to contact the parents in time. This includes any general anaesthetic and surgical procedure under the NHS. This also applies when pupils are on day or residential trips organised by the School.

Medical treatment received during school holidays

Parents are asked to inform the School Nurse at the start of term if a pupil receives any significant medical treatment. This can be detailed on the annual medical update form, or by phone or email to the School Nurse if subsequent to the annual update.

Immunisations

The School recommends that all pupils should be up-to-date regarding routine immunisations in accordance with UK Health Security Agency schedules. The NHS School Immunisation Service manages the Immunisation Programme and will visit the School at different times throughout the year to administer immunisations, in line with the routine Childhood Immunisation Schedule. Southern Health will request parental consent for each immunisation programme. However, if any pupils aged16 and above have missed any vaccinations, the Immunisation Service now offers them with child-only consent.

Consent
Pupils are able to consent to medical or nursing treatment, regardless of age, if they are deemed 'competent'; otherwise parental consent, or the consent of a recognised person acting in loco parentis, is required. Authorisations concerning the dispensing of prescribed and non-prescribed medication, First Aid treatment and emergency treatment are requested on the School's Medical Form. See *Administration of Medicines Policy*.

Confidentiality
Medical information about pupils, regardless of their age, will remain confidential. However, in providing nursing care for a pupil it is recognised that, on occasions, the School Nurse may liaise with the Deputy Head – Pastoral, Headmistress, School Counsellor, other staff, parents or guardians in order to support the pupil's ongoing wellbeing. Permission to share medical information will always be saught from the pupil and parents, unless there are immediate safeguarding concerns and the pupil is considered to be at risk of immediate harm.

In addition, the School reserves the right to share medical information, for example diagnoses, with external agencies such as the Local Education Authority. This would only be done in certain circumstances, such as when arranging alternative educational provision in the case of long-term absence due to illness. If possible, parental consent will be requested first and it would be usual for parents to be aware of these agencies' involvement or requests ahead of time.

Health vulnerabilities
The School is alert to the need for vigilance concerning particular health vulnerabilities, for example anaphylaxis and eating disorders, as well as virulent strains of influenza and other contagious illnesses.

Diarrhoea and vomiting
To prevent the spread of infection in school settings, the UK Health Security Agency recommends the exclusion of any affected pupil or member of staff for a period of 48 hours from the last episode of diarrhoea and/or vomiting.

Anaphylaxis
When a child is known to be at risk of anaphylaxis their doctor will prescribe medication for use in case of an allergic reaction. This may include adrenaline injections. Those most commonly in use are the auto-injectors called EpiPens and Jext pens. A list of pupils who are at risk of an anaphylactic reaction is posted on the noticeboard in the main staffroom, in the Rennie Surgery and electronically in the All Staff folder on SharePoint. Pupils at risk are expected to carry two auto-injectors at all times. A spare generic auto-injector is kept by the School Nurse in the Rennie Surgery in case of emergency. One is also kept in the School Office, Hall Lobby and the PE department. All staff have auto-injector training and are required to review/familiarise themselves with annual updates.

Eating disorders
The School is keen to help pupils of all ages to develop healthy eating habits and values, and the promotion of healthy eating is an important area of the PSHEE programme. Sometimes, however, young people suffer from eating distress/disordered eating. Parents will always be fully informed should any concerns arise in relation to disordered eating (eating disorders) and their child. If an eating problem is subsequently diagnosed by a medical professional, a support strategy will be planned and implemented in consultation with the pupil's care team.

The School follows advice from the School Nurse, Child and Adolescent Mental Health Services (CAMHS) and health professionals treating pupils affected by eating disorders. Regular updates from a health professional at GP or consultant level would be expected, as well as any therapy services. A decision will also be made, taking into account medical advice, as to whether or not the pupil is fit to be in school. The School reserves the right to make an independent decision on this after considering a range of factors, including the impact on other pupils. If a pupil needs to be away from school for a period of time, arrangements will be made for work to be sent home, if appropriate. Again, although the School will take into account advice provided by medical professionals as to whether the provision of work is appropriate, it also reserves the right to make this decision independently. If a pupil is advised to spend a period of time away from school a home welfare visit will be arranged. This visit will usually involve the Deputy Head – Pastoral and the pupil's Head of Year. If they are not in residential care with school provision where work will be provided (dual registration), the Local Education Authority will be involved in order that they can provide inclusion education services. If the School

is not satisfied that a full picture is being provided to show the support in place, it reserves the right to make an independent decision on whether or not a pupil is fit to be in school.

Influenza

In view of the concern in recent years about virulent strains of influenza, parents are asked to keep pupils at home if they display symptoms of influenza (a cough, sore throat, headache, aching muscles and/or raised temperature). Parents are advised to seek guidance by telephone from their own doctor or from the NHS 111 advice service. The School follows government advice regarding time away from school in the case of specific strains of influenza, such as COVID-19.

Notifiable viruses

In the event of a pupil returning to school from an infected area or having been in close contact with someone who is subsequently confirmed as having a notifiable virus, this should be reported to the School Nurse prior to attending school. This will enable her to monitor the pupil's health for the required period of time (usually seven days). Should a pupil at school become infected with a notifiable virus, the School will follow the advice of the UK Health Security Agency (formerly Public Health England) and notice of the situation will be given via the School's website or electronic mailing system. Parents are asked to check this website regularly during times of sickness.

Hygiene procedures

Any spill of blood or body fluids (faeces, urine, nasal and eye discharges, saliva and vomit) is regarded as potentially infectious. When an incident occurs a suitably trained member of staff (Facilities Manager, Caretaker or members of the domestic staff) should be called to help, ensuring that the affected area is safely decontaminated and cleaned, that all waste is placed in a clinical waste bag, and any soiled clothing is sealed in a plastic bag. Staff should ensure that pupils do not come into contact with the spill and appropriate clothing should be worn, such as aprons and gloves.

First Aid Equipment

First Aid boxes are available in all the areas of the School where an accident is considered possible or likely (for example the Sports Hall). A list of first aid box locations can be found in Annex 3 below. First Aid bags are always taken when pupils go out of School for visits and sports events. As part of their induction programmes, all new pupils and staff are given information on where to go for help in the event of an accident.

The School has two auto-external defibrillators (AEDs) available to those on-site, one in the Sports Hall Lobby and one in the Hall Lobby. They are stored in clearly labelled unlocked cupboards along with a First Aid kit. All First Aid qualified staff are trained to use an AED. (A third AED is located next to the hockey astro-pitch, but is only available at certain times during the day as it is stored in a locked outside cupboard. It can be accessed by PE staff.)

Logs and Record Keeping

Records are kept of all accidents and injuries. The School Nurse will automatically record details on the daily Surgery list on which every visit to the Surgery is noted. A School Accident or Near Miss e-form will then be completed either by the School Nurse or by the member of staff concerned. It will then be viewed by the Facilities Manager, who will discuss the situation with the School Nurse if appropriate. Forms should be completed as soon as possible, and within 36 hours of the incident. There is a procedure in place for ensuring that Accident or Near Miss e-forms are reviewed regularly in order to minimise the likelihood of recurrence. Accidents resulting in major injuries or over-three-day injuries and dangerous occurrences (near-miss accidents) are reported in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR).

Role of First Aiders

In the event of an accident when the School Nurse is off-site, the member of staff first on the scene should contact the School Office and a First Aider will be deployed. If mobile, the casualty will be taken to an appropriate space such as the Rennie Surgery, School Office, Library or other appropriate area with the help, of the First Aider. A member of the Senior Leadership Team (usually the Deputy Head – Pastoral) should also be informed by the School Office. The First Aider should assess the casualty and deal appropriately with the injury in accordance with First Aid principles. If the casualty cannot be moved, the First Aider should make an assessment at the scene of the accident in accordance with First Aid principles (or procedures) and deal appropriately with the injury. The First Aider will decide when to call an ambulance, with the support of senior

staff. Members of staff qualified as First Aiders may be called to assist with an emergency. Please also refer to the *Educational Visits Policy* for more information on trips.

Staff with a qualification in First Aid are required to update their training every three years.

This policy is reviewed annually by the School Nurse, Deputy Head – Pastoral and Bursar.

The next review is due in September 2026.

Annex 1: Administration of Medicines Policy

ADMINISTRATION OF MEDICINES POLICY

This policy should be read in conjunction with the:

- Educational Visits Policy
- Health Care and First Aid Policy
- Supporting Pupils with Medical Conditions Policy

The School recognises the importance of having a clear policy for the administration of medicines that is made known to, understood and accepted by staff, parents and pupils and which provides a sound basis to ensure the proper and safe administration of both prescribed and non-prescribed medications.

The school employs two registered School Nurses who are the primary administrators of any medications given in school. In the event that the School Nurse is unavailable, there are select members of staff who can administer medication. These members of staff have been trained by the School Nurse. They will have read through this *Administration of Medicines Policy* and met with the School Nurse to discuss the policy. They will also have signed a form to confirm that they have received the training (see Annex 2). This will be updated annually.

1 Homely remedies

- Homely remedies are medications, creams or medical wipes that can be purchased over-the-counter and do not require a prescription. All homely remedy medications will be used in accordance with the manufacturer's guidelines.
- Homely remedies are kept securely in a locked cabinet within the Rennie Surgery.
- Medications stocked are listed on the confidential Medical Report Form which is completed by parents of new pupils.
- Written parental consent to administer these medications is requested on the confidential Medical Report Form and then documented electronically.
- Consent is always checked before administration of these medicines. If written consent has not been received, telephone consent is required and will be clearly documented electronically.
- Treatment is monitored by the School Nurse and, should medication be required regularly for more than three days, medical advice is sought.
- Any adverse reactions or concerns are reported immediately to the School Nurse or the School Office.
- If an error is made in the administration of medication, the School Nurse or administering staff member will firstly ensure the pupil's safety and well-being. They will then follow the manufacturer's guidance related to the particular medication and seek appropriate medical advice. A member of the Senior Leadership Team (normally the Deputy Head – Pastoral) will be informed, as well as the pupil's parents.

2 Prescribed medications

- During the school day, the School Nurse will administer prescribed drugs unless otherwise agreed with the School Office.
- It is essential in certain cases, such as diabetes and asthma, for pupils to understand the importance of their medication and to carry it with them at all times. They need to be responsible in the care and storage of their medication and to be compliant in taking it regularly.
- Prescribed medications must be issued only to the pupils for whom they have been prescribed.
- Medications must be given to the School Nurse in their original container as dispensed by a pharmacist, and include the prescriber's instructions.
- Any foreign medication brought to school should be in a formally translated format and authorised by the School Nurse.
- A permission form to administer prescribed medication must be completed by parents.
- No pupil will be given prescription medication without parental written consent.

- Where appropriate, certain members of staff accompanying school trips will also be trained to administer medication, if a pupil requiring this type of support is taking part.

3 Controlled drugs

- Some medicines are controlled by the Misuse of Drugs Act and its associated regulations. If a pupil has been prescribed one of these drugs the School Nurse and staff who have been trained and assessed as competent can administer these medications as prescribed.
- Controlled drugs are kept in a locked non-portable cabinet in the Rennie Surgery.
- When received at school, all controlled drugs are recorded in the log book and a balance of the amount is noted at each administration.
- Controlled drugs, as with all medicines, are returned to parents when no longer required so that they can arrange for safe disposal (by returning the unwanted supply to the local pharmacy).

4 Self-administration of medication

- In certain situations the School Nurse may agree to a pupil self-administering medication. Prior to agreeing to self-medication for a pupil, the School Nurse will assess the pupil's capacity to understand the nature of any medication given, the dose and the length of time for which it is to be taken, and any side effects.
- Every pupil who self-medicates and their parents must sign an appropriate form indicating agreement with this policy (see Annex 1c).
- Pupils who self-medicate should store their medication safely and securely, for example in their locked locker. They should only hold enough medication for one dosage or their daily allowance.
- Under no circumstances should pupils self-administer medication unless they have received permission from the School Nurse and the steps above have been taken.

5 Recording and monitoring of records

- A complete current record is kept, providing a complete audit trail for all medications.
- The School Nurse keeps an up-to-date record of all current prescribed medication, complete with a signed consent form.
- All medicines brought into school for administration by the School Nurse are recorded electronically for each pupil, including non-prescribed and complementary medicines.
- The School Nurse keeps a record of repeat medication requested and checks that this has been received.
- A record is kept of medicines sent home or on residential visits with the pupil and if a pupil is admitted to hospital.
- The School Nurse informs parents if a pupil refuses to take medication.

6 Disposal of medicines

- Medications which have expired (or where the pupil has left the School) will be safely disposed of at a local pharmacy by the School Nurse.
- Medications of existing pupils which are no longer required will be returned to parents so that they can arrange for safe disposal (by returning the unwanted supply to the local pharmacy).
- After a school trip, any unused medications should be returned directly to parents. If this is not possible the School Nurse will store or dispose of the medication in line with this policy. The name and signature of the member of staff returning the medication will be obtained.

7 Pupils who require inhalers

- All pupils who require inhalers must keep them, clearly labelled, with them at all times.
- Pupils may keep a spare named inhaler in the Rennie Surgery.
- The School Nurse will regularly check that spare inhalers are within their expiry date.
- Parents are responsible for replacing medication which is out of date.
- Parents are also responsible for completing an asthma care plan each academic year, even if there are no particular updates.
- Spare generic inhalers are kept in the Rennie Surgery for emergencies.
- A list of pupils who carry inhalers is displayed on a designated board in the staffroom.

8 Pupils who require auto-injectors

- Pupils who are prescribed an auto-injector, such as an EpiPen or Jext, are required to carry two named ones with them at all times.
- Each pupil with a prescribed auto-injector has a written care plan in the Rennie Surgery. Parents are requested to complete a new care plan (allergy plan) each academic year, even if there are no changes.
- Parents are responsible for checking that auto-injectors carried by pupils are within their expiry date and for replacing medication when it has expired.
- A spare generic auto-injector is kept in the Rennie Surgery for emergencies. One is also kept in the School Office, Hall Lobby and PE Department.
- A wide range of staff receive annual training in the use of auto-injectors.
- A photo list of pupils who require auto-injectors is displayed on a designated board in the staffroom.

9 Pupils with special medical needs

- Each pupil with a formally diagnosed medical condition is assessed by the School Nurse to ascertain whether they require an IHCP (Individual Health Care Plan). All pupil IHCPs are available to staff on the Shared Drive (All Staff folder). A photo list of pupils with medical conditions is displayed on a designated board in the staffroom.

10 Trips

- As part of trip arrangements, day and residential, the School Nurse liaises closely with the First Aider going on the trip. *See Educational Visits Policy.*

This policy is reviewed annually by the School Nurse and Deputy Head – Pastoral.

The next review is due in September 2026.

Annex 1a: Administration of medication by staff other than the School Nurse

Medication

- In the absence of the School Nurse, medication can only be administered by staff who have been trained in medicine administration and assessed as competent by the School Nurse. They should only give medication that is detailed in the *Administration of Medicines Policy.*
- These members of staff should read and fully understand the *Administration of Medicines Policy*.
- Medication should only be given in accordance with the manufacturer's administration guidelines on the medication box or bottle.

Homely Remedies

- **Paracetamol**
  When appropriate to administer: Headaches, period pains, migraines, muscular aches and pains, raised temperatures.
- **Ibuprofen**
  When appropriate to administer: Muscular pain, dental pain, sports injury, period pains.
  Not to be given to any pupil who is asthmatic. Always to be given on a full stomach.
- **Cetirizine**
  When appropriate to administer: Hay fever, allergic reaction.
  Inform parents if given to treat an allergic reaction.
- **Chlorphenamine maleate (Piriton)**
  When appropriate to administer: Hay fever, allergic reaction.
  Inform parents if given to treat an allergic reaction.
- **Anthisan** (Insect bite relief cream)
  When appropriate to administer: Wasp and bee stings or any other type of insect bites. Also stinging nettle rash.
- **Throat lozenge (Strepsils)**
  When appropriate to administer: Tickly coughs.
- **Rehydration sachet (Dioralyte)**
  When appropriate to administer: Acute diarrhoea.
  Note, it will not stop the diarrhoea but is intended to replace essential body water and salts.

Annex 1b: Staff administration of medicines training record

Name: …….

Job Title: …….

Type of training received (initial each one):

- Medication groups – ie analgesia, anti-histamines antibiotics, etc
- Which medication to choose for which ailment (see Annex 1a)
- Administration checks (Name, DoB, parental consent, dose, expiry, when last administered)
- Storage of medication including controlled drugs

Date training completed: ……

Trainer confirmation:

I confirm that …….. [name of staff member] has received the training detailed above and is competent to carry out any necessary treatment. I recommend that the training is updated annually.

School Nurse signature: ……

Date: ……..

Staff confirmation:

I confirm that I have received the training detailed above.

Staff signature: ……

Date: ……..

Suggested Review Date: ……

Annex 1c: Self-administration of medicine in School Form

Self-administration of Medication in School

Pupil's name: …… Form: …….

Parent/Guardian contact numbers:

Home: ……..……..

Mobile: ……..……..…..……...

Work: ……...……...……...

GP: ……..……...…….

Name of medication	Dose	Times to be taken	Duration of course	Any special instructions

Terms of agreement to carry and self-administer own medication:

- The medication must be carried in its original packaging and kept securely, for example in a locked locker.
- The pupil will be in possession of only one dose or the daily allowance of medication.
- The pupil understands that the medication is **solely for their personal use** and must not be shared with any other pupil.
- All relevant information about the medication must be provided on this form.
- Self-administration of medication will be reviewed periodically by the School Nurse and can be withdrawn at any time if appropriate, or the above terms are not adhered to.

Parent/Guardian: I consent for my daughter to take the medication named above in school and agree to the terms of self-administration above.

Signature of Parent/Guardian: ……. Date: …….

Pupil: I agree to the terms of self-administration of my medication in school as stated above.

Signature of Pupil: …… Date: …….

Editorial

Child SCAT6

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Child SCAT6™

Sport Concussion Assessment Tool

For Children Ages 8 to 12 Years

What is the SCAT6?

The Child SCAT6 is a standardised tool for evaluating concussions in children ages 8-12 years, and designed for use by Health Care Professionals (HCP). The Child SCAT6 cannot be performed correctly in less than 10-15 minutes. The Child SCAT6 is intended to be used in the acute phase, ideally within 72 hours (3 days), and up to 7 days, following injury. If greater than 7 days post-injury consider using the Child Sport Concussion Office Assessment Tool 6 (Child SCOAT6).[1]

The Child SCAT6 is used for evaluating children aged 8-12 years. For athletes aged 13 years or older, please use the SCAT6.[2]

If you are not an HCP, please use the Concussion Recognition Tool 6 (CRT6).[3]

Detailed instructions for use of the Child SCAT6 are provided as a supplement. Please read through these instructions carefully before using the Child SCAT6. Brief verbal instructions for each test are given in ***blue italics***. The only equipment required for the examiner is athletic tape and a watch or timer.

Recognise and Remove

A head impact by either a direct blow or indirect transmission of force to the head can be associated with serious and potentially fatal consequences. If there are significant concerns, including any of the RED FLAGS listed in Box 1 indicating signs that require urgent medical attention, and if a qualified medical practitioner is not present for immediate sideline assessment, then activation of emergency procedures and urgent transport to the nearest hospital should be arranged.

Key Points

- Any child with suspected concussion should be IMMEDIATELY REMOVED FROM PLAY, medically assessed, and monitored for injury-related signs, including deterioration of clinical condition.
- No child with a suspected concussion should be returned to play on the day of injury.
- If a child is suspected of having a concussion, and medical personnel are not immediately available, the child should be referred (or transported if needed) to a medical facility for assessment.
- Children with suspected or diagnosed concussion should not be given medications such as aspirin, anti-inflammatories, sedatives or opiates.
- Concussion signs and symptoms may evolve over time and it is important to monitor the child for ongoing, worsening, or development of concussion-related symptoms.
- The Child SCAT6 should not be used in isolation in making post-acute return to play decisions.
- The diagnosis of a concussion is a clinical determination made by a HCP. The Child SCAT6 should NOT be used by itself to make, or exclude, the diagnosis of concussion. It is important to note that a child may have a concussion even if their Child SCAT6 assessment is within normal limits.

Remember

- The basic principles of first aid should be followed: assess danger at the scene, child responsiveness, airway, breathing, and circulation.
- Do not attempt to move an unconscious/unresponsive child (other than that required for airway management) unless trained to do so.
- Assessment for a spinal and/or spinal cord injury is a critical part of the initial on-field assessment. Do not attempt to assess the spine unless trained to do so.
- Do not remove a helmet or any other equipment unless trained to do so safely.

Completion Guide

Blue: Required part of assessment

Orange: Optional part of assessment

For use by Health Care Professionals Only — Child SCAT6™

Developed by: The Concussion in Sport Group (CISG)

Supported by:

International Olympic Committee · FEI · FIA · FIFA · IIHF · World Rugby

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Child SCAT6© Sport Concussion Assessment Tool

For Children Ages 8 to 12 Years

Child Name:			
ID Number:		**Date of Birth:**	
Date of Examination:		**Date of Injury:**	**Time of Injury:**
Sex: Male ☐ Female ☐ Prefer Not To Say ☐		**Dominant Hand:** Left ☐ Right ☐ Ambidextrous ☐	
Sport/Team/School:		**Current Year/Grade Level in School:**	
First Language:		**Preferred Language:**	
Examiner:			

Concussion History

How many diagnosed concussions has the child had in the past?:	
When was the most recent concussion?:	
Primary Symptoms:	
How long was the recovery (time to being cleared to play) from the most recent concussion?:	**(Days)**

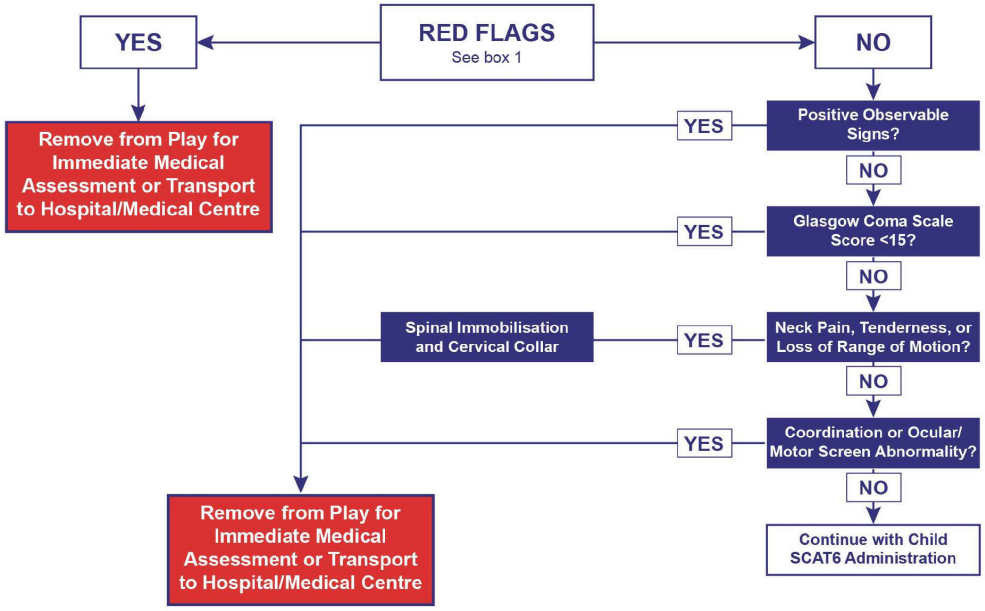
Immediate Assessment/Neuro Screen (Not Required at Baseline)

The following elements should be used in the evaluation of all children who are suspected of having a concussion prior to proceeding to the cognitive assessment, and ideally should be completed "on-field" after the first aid/emergency care priorities are completed.

If any of the observable signs of concussion are noted after a direct or indirect blow to the head, the child should be immediately and safely removed from participation and evaluated by a HCP.

Consideration of transportation to a medical facility should be at the discretion of the physician or HCP.

The Glasgow Coma Scale[4] is important as a standard measure for all patients and can be repeated over time to monitor deterioration of consciousness. The cervical spine examination is also a critical step in the immediate assessment.



Child Sport Concussion Assessment Tool 6 - Child SCAT6™

Step 1: Observable Signs

Witnessed ☐ Observed on Video ☐

Lying motionless on playing surface	Y	N
Falling unprotected to the surface	Y	N
Balance/gait difficulties, motor incoordination, ataxia: stumbling, slow/laboured movements	Y	N
Disorientation or confusion, staring or limited responsiveness, or an inability to respond appropriately to questions	Y	N
Blank or vacant look	Y	N
Facial injury after head trauma	Y	N
Impact seizure	Y	N
High-risk mechanism of injury (sport-dependent)	Y	N

Step 2: Glasgow Coma Scale[4]

Typically, GCS is assessed once. Additional scoring columns are provided for monitoring over time, if needed.

Time of Assessment:

Date of Assessment:

Best Eye Response (E)			
No eye opening	1	1	1
Eye opening to pain	2	2	2
Eye opening to speech	3	3	3
Eyes opening spontaneously	4	4	4

Best Verbal Response (V)			
No verbal response	1	1	1
Incomprehensible sounds	2	2	2
Inappropriate words	3	3	3
Confused	4	4	4
Oriented	5	5	5

Best Motor Response (V)			
No motor response	1	1	1
Extension to pain	2	2	2
Abnormal flexion to pain	3	3	3
Flexion/withdrawal to pain	4	4	4
Localized to pain	5	5	5
Obeys commands	6	6	6

Glasgow Coma Score (E + V + M)			

Box 1: Red Flags

- Neck pain or tenderness
- Seizure or convulsion
- Double vision
- Loss of consciousness
- Weakness or tingling/burning in more than 1 arm or in the legs
- Deteriorating conscious state
- Vomiting
- Severe or increasing headache
- Increasingly restless, agitated or combative
- GCS <15
- Visible deformity of the skull

Step 3: Cervical Spine Assessment

In a child who is not lucid or fully conscious, a cervical spine injury should be assumed and spinal precautions taken.

Does the child report neck pain at rest?	Y	N
Is there tenderness to palpation?	Y	N
If NO neck pain and NO tenderness, does the athlete have a full range of ACTIVE pain free movement?	Y	N
Are limb strength and sensation normal?	Y	N

Step 4: Coordination & Oculomotor Screen

Coordination: Is finger-to-nose normal for both hands with eyes open and closed?	Y	N
Ocular/Motor: Without moving their head or neck, can the patient look side-to-side and up-and-down without double vision?	Y	N
Are observed extraocular eye movements normal? If not, describe:	Y	N

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Off-Field Assessment

Please note that the cognitive assessment should be done in a distraction-free environment with the child in a resting state **after** completion of the Immediate Assessment/Neuro Screen.

Step 1: Child Background

Has the child ever been:

Hospitalised for head injury? (If yes, describe below)	Y N	Diagnosed with attention deficit hyperactivity disorder (ADHD)?	Y N
Diagnosed/treated for headache disorder or migraine?	Y N	Diagnosed with depression, anxiety, or other psychological disorder?	Y N
Diagnosed with a learning disability/dyslexia?	Y N		

Notes:

Is the child on any medications? If yes, please list:

Step 2: Symptom Evaluation - Child Report

Baseline: ☐ **Suspected/Post-injury:** ☐ **Time elapsed since suspected injury:** _____ mins/hours/days

The child will complete the symptom scale[5] (below) after you provide instructions. Please note that the instructions are different for baseline versus suspected/post-injury evaluations.

Baseline: Say ***"Please rate your symptoms below based on how you typically feel with "1" representing the symptom is a little and "3" representing the symptom is a lot."***

Suspected/Post-injury: Say ***"Please rate your symptoms below based on how you feel now with "1" representing the symptom is a little and "3" representing the symptom is a lot."***

PLEASE HAND THE FORM TO THE CHILD

Symptom	Not at all/never	A little/rarely	Somewhat/ sometimes	A lot/often
I have headaches	0	1	2	3
I feel dizzy	0	1	2	3
I feel like the room is spinning	0	1	2	3
I feel like I'm going to faint	0	1	2	3
Things are blurry when I look at them	0	1	2	3
I see double	0	1	2	3
I feel sick to my stomach	0	1	2	3
I get tired a lot	0	1	2	3
I get tired easily	0	1	2	3
I have trouble paying attention	0	1	2	3
I get distracted easily	0	1	2	3
I have a hard time concentrating	0	1	2	3
I have problems remembering what people tell me	0	1	2	3
I have problems following directions	0	1	2	3
I daydream too much	0	1	2	3
I get confused	0	1	2	3
I forget things	0	1	2	3
I have problems finishing things	0	1	2	3
I have trouble figuring things out	0	1	2	3
It's hard for me to learn new things	0	1	2	3
My neck hurts	0	1	2	3

Do the symptoms get worse with physical activity?	Y N
Do the symptoms get worse with trying to think?	Y N

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Step 2: Symptom Evaluation - Child Report (Continued)

Overall rating for child to answer:

On a scale of 0 to 10 (where 10 is normal), how do you feel now?	Very Bad 0 1 2 3 4 5 6 7 8 9 10 Very Good

If not 10, in what way do you feel different?

PLEASE HAND THE FORM BACK TO THE EXAMINER

Child Report: Total number of symptoms: _____ **of 21** **Symptom severity score:** _____ **of 63**

Step 2: Symptom Evaluation - Parent Report

PLEASE HAND THE FORM TO THE PARENT/GUARDIAN/CARER

The Child...	Not at all/never	A little/rarely	Somewhat/ sometimes	A lot/often
has headaches	0	1	2	3
feels dizzy	0	1	2	3
has a feeling that the room is spinning	0	1	2	3
feels faint	0	1	2	3
has blurred vision	0	1	2	3
has double vision	0	1	2	3
experiences nausea	0	1	2	3
gets tired a lot	0	1	2	3
gets tired easily	0	1	2	3
has trouble sustaining attention	0	1	2	3
is distracted easily	0	1	2	3
has difficulty concentrating	0	1	2	3
has problems remembering what he/she is told	0	1	2	3
has difficulty following directions	0	1	2	3
tends to daydream	0	1	2	3
gets confused	0	1	2	3
is forgetful	0	1	2	3
has difficulty completing tasks	0	1	2	3
has poor problem-solving skills	0	1	2	3
has problems learning	0	1	2	3
has a sore neck	0	1	2	3

Do the symptoms get worse with physical activity?	Y	N
Do the symptoms get worse with trying to think?	Y	N

Overall rating for parent/teacher/coach/carer to answer:

On a scale of 0 to 100% (where 100% is normal), how would you rate the child now?	

If not 100%, in what way does the child seem different?

PLEASE HAND THE FORM BACK TO THE EXAMINER

Parent Report: Total number of symptoms: _____ **of 21** **Symptom severity score:** _____ **of 63**

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Step 3: Cognitive Screening (Based on Standardized Assessment of Concussion; SAC)[6]

Immediate Memory

All 3 trials must be administered irrespective of the number correct on Trial 1. Administer at the rate of one word per second in a monotone voice.

Trial 1: Say *"I am going to test your memory. I will read you a list of words and when I am done, repeat back as many words as you can remember, in any order."*

Trials 2 and 3: Say *"I am going to repeat the same list. Repeat back as many words as you can remember in any order, even if you said the word before in a previous trial."*

Word list used: A ☐ B ☐ C ☐

				Alternate Lists	
List A	Trial 1	Trial 2	Trial 3	List B	List C
Finger	0 1	0 1	0 1	Baby	Jacket
Penny	0 1	0 1	0 1	Monkey	Arrow
Blanket	0 1	0 1	0 1	Perfume	Pepper
Lemon	0 1	0 1	0 1	Sunset	Cotton
Insect	0 1	0 1	0 1	Iron	Movie
Candle	0 1	0 1	0 1	Elbow	Dollar
Paper	0 1	0 1	0 1	Apple	Honey
Sugar	0 1	0 1	0 1	Carpet	Mirror
Sandwich	0 1	0 1	0 1	Saddle	Saddle
Wagon	0 1	0 1	0 1	Bubble	Anchor
Trial Total					

Time last trial completed:

Immediate Memory Score	of 30

Concentration

Digits Backward:

Administer at the rate of one digit per second in a monotone voice reading DOWN the selected column.

Say *"I'm going to read a string of numbers and when I am done, you repeat them back to me in reverse order of how I read them to you. For example, if I say 7-1-9, you would say 9-1-7. So, if I said 9-6-8 you would say? (8-6-9)"*

Digit list used: A ☐ B ☐ C ☐

List A	List B	List C			
5-2	4-1	4-9	Y	N	0 1
4-1	9-4	6-2	Y	N	
4-9-3	5-2-6	1-4-2	Y	N	0 1
6-2-9	4-1-5	6-5-8	Y	N	
3-8-1-4	1-7-9-5	6-8-3-1	Y	N	0 1
3-2-7-9	4-9-6-8	3-4-8-1	Y	N	
6-2-9-7-1	4-8-5-2-7	4-9-1-5-3	Y	N	0 1
1-5-2-8-6	6-1-8-4-3	6-8-2-5-1	Y	N	
7-1-8-4-6-2	8-3-1-9-6-4	3-7-6-5-1-9	Y	N	0 1
5-3-9-1-4-8	7-2-4-8-5-6	9-2-6-5-1-4	Y	N	
			Digits Score		of 5

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Step 3: Cognitive Screening (Continued)

Days in Reverse Order:

Say ***"Now tell me the days of the week in reverse order as QUICKLY and as accurately as possible. Start with the last day and go backward. So, you'll say Sunday, Saturday… go ahead"***

Start stopwatch and CIRCLE each correct response:

Sunday Saturday Friday Thursday Wednesday Tuesday Monday

Time Taken to Complete (secs): **Number of Errors:**

1 point if no errors and completion under 30 seconds

Days Score: **of 1**

Concentration Score (Digits + Days) **of 6**

Step 4: Coordination and Balance Examination

Modified Balance Error Scoring System (mBESS)[7] testing

(see detailed administration instructions)

Foot Tested: Left ☐ **Right** ☐ (i.e. test the **non-dominant** foot)

Testing Surface (hard floor, field, etc.):

Footwear (shoes, barefoot, braces, tape etc.):

OPTIONAL (depending on clinical presentation and setting resources): For further assessment, the same 3 stances can be performed on a surface of medium density foam (e.g., approximately 50cm x 40cm x 6cm) with the same instructions and scoring.

Modified BESS (20 seconds each)			On Foam (Optional)		
Double Leg Stance:		of 10	Double Leg Stance:		of 10
Tandem Stance:		of 10	Tandem Stance:		of 10
Single Leg Stance:		of 10	Single Leg Stance:		of 10
Total Errors:		of 30	Total Errors:		of 30

Note: If the mBESS yields negative or questionable findings then proceed to the **Tandem Gait/Complex/Dual-Task Tandem Gait**. If the mBESS reveals clinically significant difficulties, **Tandem Gait** is not necessary at this time. The **Tandem Gait**, **Complex Tandem Gait** and optional **Dual-Task** component may be administered later in the office setting as needed.

Timed Tandem Gait

Place a 3-metre-long line on the floor/firm surface with athletic tape. The task should be timed.

Say ***"Please walk heel-to-toe quickly to the end of the tape, turn around and come back as fast as you can without separating your feet or stepping off the line."***

Single Task:

Time to Complete Tandem Gait Walking (seconds)				
Trial 1	Trial 2	Trial 3	Average 3 Trials	Fastest Trial

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Step 4: Coordination and Balance Examination (Continued)

Complex Tandem Gait

Forward

Say ***"Please walk heel-to-toe quickly five steps forward, then continue forward with eyes closed for five steps"*** 1 point for each step off the line, 1 point for truncal sway.

Forward Eyes Open	**Points:**	
Forward Eyes Closed	**Points:**	
	Forward Total Points:	

Backward

Say ***"Please walk heel-to-toe again, backwards five steps eyes open, then continue backwards five steps with eyes closed."*** 1 point for each step off the line, 1 point for truncal sway.

Backward Eyes Open	**Points:**	
Backward Eyes Closed	**Points:**	
	Backward Total Points:	

Total Points (Forward + Backward):

Dual Task Gait (Optional)

Only perform if the child successfully completes complex tandem gait.

Place a 3-metre-long line on the floor/firm surface with athletic tape. The task should be timed.

Say ***"Now, while you are walking heel-to-toe, I will ask you to count backwards out loud by 3s. For example, if we started at 100, you would say 100, 97, 94, 91. Let's practise counting. Starting with 95, count backward by threes until I say "stop"."*** Note that this practice only involves counting backwards.

Dual Task Practice: Circle correct responses; record number of subtraction counting errors.

Task									Errors	Time
Practice	95	92	89	86	83	80	77	74		

Say ***"Good. Now I will ask you to walk heel-to-toe and count backwards out loud at the same time. Are you ready? The number to start with is 88. Go!"***

Dual Task Cognitive Performance: Circle correct responses; record number of subtraction counting errors.

Task									Errors	Time (circle fastest)
Trial 1	88	85	82	79	76	73	70	67		
Trial 2	76	73	70	67	64	61	58	55		
Trial 3	93	90	87	84	81	78	75	72		

Alternate double number starting integers may be used and recorded below.

Starting Integer: **Errors:** **Time:**

Were any single- or dual-task, timed tandem gait trials not completed due to walking errors or other reasons?

Yes ☐ **No** ☐

If yes, please explain why:

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Step 5: Delayed Recall

The Delayed Recall should be performed after **at least 5 minutes** have elapsed since the end of the Immediate Memory section: **Score 1 point for each correct response.**

Say ***"Do you remember that list of words I read a few times earlier? Tell me as many words from the list as you can remember in any order."***

Time started:

Word list used: A ☐ B ☐ C ☐

List A	Score	Alternate Lists: List B	Alternate Lists: List C
Finger	0 1	Baby	Jacket
Penny	0 1	Monkey	Arrow
Blanket	0 1	Perfume	Pepper
Lemon	0 1	Sunset	Cotton
Insect	0 1	Iron	Movie
Candle	0 1	Elbow	Dollar
Paper	0 1	Apple	Honey
Sugar	0 1	Carpet	Mirror
Sandwich	0 1	Saddle	Saddle
Wagon	0 1	Bubble	Anchor
Delayed Recall Score	of 10		

If the athlete was known to you prior to their injury, are they different from their usual self?

Yes ☐ **No** ☐ **Not applicable** ☐ (If different, describe why In the clinical notes section)

Step 6: Decision

Domain	Date:	Date:	Date:
Immediate Assessent/Neuro Screen	Normal/Abnormal	Normal/Abnormal	Normal/Abnormal
Symptom number (of 21) Child Report Parent Report			
Symptom Severity (of 63) Child Report Parent Report			
Immediate Memory (of 30)			
Concentration (of 6)			
Delayed Recall (of 10)			
Cognitive Total Score (of 46)			
mBESS Total Errors (of 30)			
Tandem Gait fastest time			
Complex Tandem Gait Total Points			
Dual Task fastest time			

Disposition

Concussion diagnosed? **Yes** ☐ **No** ☐ **Deferred** ☐

If re-testing, has the child improved? **Yes** ☐ **No** ☐

Describe:

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Health Care Professional Attestation

I am an HCP and I have personally administered or supervised the administration of this Child SCAT6.

Name:

Signature: **Title/Speciality:**

Registration/License number (if applicable): **Date:**

Additional Clinical Notes

Note: Scoring on the Child SCAT6 should not be used as a stand-alone method to diagnose concussion, measure recovery, or make decisions about a child's readiness to return to sport after concussion. Remember, a child can score within normal limits on the Child SCAT6 and still have a concussion. Wherever possible, the results of the Child SCAT6 should accompany the child to any later reassessments by an HCP.

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Competing interests GAD is a member of the Scientific Committee of the 6th International Consensus Conference on Concussion in Sport; an honorary member of the AFL Concussion Scientific Committee; Section Editor, Sport and Rehabilitation, NEUROSURGERY; and has attended meetings organised by sporting organisations including the NFL, NRL, IIHF, IOC and FIFA; however has not received any payment, research funding or other monies from these groups other than for travel costs. Dr RJE is a paid consultant for the NHL and cochair of the NHL/ NHLPA Concussion Subcommittee. He is also a paid consultant and chair of the Major League Soccer concussion committee and a consultant to the US Soccer Federation. He previously served as a neuropsychology consultant to Princeton University Athletic Medicine and EyeGuide. He is currently a co-PI for a grant funded by the NFL (NFL-Long) through Boston Children's Hospital. 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She is a member of the AFL Concussion Scientific Committee (unpaid position), Brain Canada (unpaid positions) and Board member of the Concussion in Sport Group (CISG) (unpaid). She works as a physiotherapy consultant and treats athletes of all levels of sport from grass roots to professional. Dr SRW reports receipt of honorarium from the National Athletic Trainers' Association (NATA) for presentation and travel to the 2022 World Congress of the World Federation of Athletic Training and Therapy (WFATT). Dr Walton serves as the Chair of Marketing and Promotions for the WFATT and as a member of the Outcomes working group for the International Initiative for Traumatic Brain Injury Research (InTBIR). Dr Walton reports work on research projects funded by the National Football League (NFL), National Collegiate Athletic Association (NCAA), Department of Defense (DoD) and Department of Veterans Affairs in the United States, and these entities do not oversee or provide input on his research or service efforts. Dr KOY: is Editor-in-Chief of the journal Neuropsychology and receive an editorial stipend from the American Psychological Association. I am an unpaid consulting editor for the journals Archives of Clinical Neuropsychology and Journal of Head Trauma Rehabilitation. I am an unpaid member of the Scientific Advisory Committee for Brain Injury Canada. I am the chair of the Canadian Concussion Network, which is funded by a grant from Canadian Institutes of Health Research (CIHR) to my institution; I am principal applicant on the grant but receive no income from it. I am a principal investigator on another grant from CIHR from which I derive no income. I am a co-investigator on research grants from CIHR, the US National Institutes ofHealth (NIH), Brain Canada Foundation, and National Football League Scientific Advisory Board; I derive income only from the grant from NIH. I serve as a member of a CIHR grant review panel for which I receive a small honorarium. I receive book royalties from Guilford Press and Cambridge University Press. I have received travel support and honorarium for presentations to multiple organisations. I served or serve on the following committees/boards for which I receive(d) honorarium: 1. Independent Data Monitoring Committee (IDMC), Care for Post-Concussive Symptoms E eciveness (CARE4PCS-2) Trial, National Institute for Child Health and Human Development 2. Observational Study Monitoring Board (OSMB), Approaches and Decisions in Acute Pediatric TBI (ADAPT) Trial, National Institute of Neurological Disorders and Stroke National Research Advisory Council, National Pediatric Rehabilitation Resource Center, Center for Pediatric Rehabilitation: Growing Research, Education and Sharing Science (C-PROGRESS),Virginia Tech University. Dr RZ has current or past competitively-funded research grants from Canadian Institutes of Health Research (CIHR), National Institutes of Health (NIH), Health Canada, Ontario Neurotrauma Foundation (ONF), Ontario Ministry of Health, Physician Services Incorporated (PSI) Foundation, CHEO Foundation, University of Ottawa Brain and Mind Research Institute,Ontario Brain Institute (OBI), and Ontario SPOR Support Unit (OSSU) and the National FootballLeague (NFL) Scientific Advisory Board. I hold Clinical Research Chair in Pediatric Concussion from University of Ottawa, and I am on the advisory board for Parachute Canada (a non-profitinjury prevention charity) and the board of directors for the North American Brain Injury Society (unpaid). I am the co-founder, Scientific Director and a minority shareholder in 360 Concussion Care, an interdisciplinary concussion clinic.

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Appendix 2b: Sport Concussion Assessment Tool For Adolescents (13 years +) and Adults (for use by School Nurse only)

SCAT6™

Sport Concussion Assessment Tool

For Adolescents (13 years +) & Adults

What is the SCAT6?

The SCAT6 is a standardised tool for evaluating concussions designed for use by Health Care Professionals (HCPs). The SCAT6 cannot be performed correctly in less than 10-15 minutes. Except for the symptoms scale, the SCAT6 is intended to be used in the acute phase, ideally within 72 hours (3 days), and up to 7 days, following injury. If greater than 7 days post-injury, consider using the SCOAT6/Child SCOAT6.

The SCAT6 is used for evaluating athletes aged 13 years and older. For children aged 12 years or younger, please use the Child SCAT6.

If you are not an HCP, please use the Concussion Recognition Tool 6 (CRT6).

Preseason baseline testing with the SCAT6 can be helpful for interpreting post-injury test scores but is not required for that purpose. Detailed instructions for use of the SCAT6 are provided as a supplement. Please read through these instructions carefully before testing the athlete. Brief verbal instructions for each test are given in ***blue italics***. The only equipment required for the examiner is athletic tape and a watch or timer.

Recognise and Remove

A head impact by either a direct blow or indirect transmission of force to the head can be associated with serious and potentially fatal consequences. If there are significant concerns, which may include any of the Red Flags listed in Box 1, the athlete requires urgent medical attention, and if a qualified medical practitioner is not available for immediate assessment, then activation of emergency procedures and urgent transport to the nearest hospital or medical facility should be arranged.

Completion Guide

Orange: Optional part of assessment

Key Points

- Any athlete with suspected concussion should be REMOVED FROM PLAY, medically assessed, and monitored for injury-related signs and symptoms, including deterioration of their clinical condition.
- No athlete diagnosed with concussion should return to play on the day of injury.
- If an athlete is suspected of having a concussion and medical personnel are not immediately available, the athlete should be referred (or transported if needed) to a medical facility for assessment.
- Athletes with suspected or diagnosed concussion should not take medications such as aspirin or other anti-inflammatories, sedatives or opiates, drink alcohol or use recreational drugs and should not drive a motor vehicle until cleared to do so by a medical professional.
- Concussion signs and symptoms may evolve over time; it is important to monitor the athlete for ongoing, worsening, or the development of additional concussion-related symptoms.
- The diagnosis of concussion is a clinical determination made by an HCP.
- The SCAT6 should NOT be used by itself to make, or exclude, the diagnosis of concussion. It is important to note that an athlete may have a concussion even if their SCAT6 assessment is within normal limits.

Remember

- The basic principles of first aid should be followed: assess danger at the scene, athlete responsiveness, airway, breathing, and circulation.
- Do not attempt to move an unconscious/unresponsive athlete (other than what is required for airway management) unless trained to do so.
- Assessment for a spinal and/or spinal cord injury is a critical part of the initial on-field evaluation. Do not attempt to assess the spine unless trained to do so.
- Do not remove a helmet or any other equipment unless trained to do so safely.

For use by Health Care Professionals Only **SCAT6™**

Developed by: The Concussion in Sport Group (CISG)

Supported by:

International Olympic Committee

SCAT6™ Sport Concussion Assessment Tool

For Adolescents (13 years +) & Adults

Athlete Name:				**ID Number:**	
Date of Birth:		**Date of Examination:**		**Date of Injury:**	
Time of Injury:		**Sex:** Male ☐	Female ☐	Prefer Not To Say ☐	Other
Dominant Hand: Left ☐	Right ☐	Ambidextrous ☐		**Sport/Team/School:**	
Current Year in School (if applicable):				**Years of Education Completed (Total):**	
First Language:				**Preferred Language:**	
Examiner:					

Concussion History

How many diagnosed concussions has the athlete had in the past?:

When was the most recent concussion?:

Primary Symptoms:

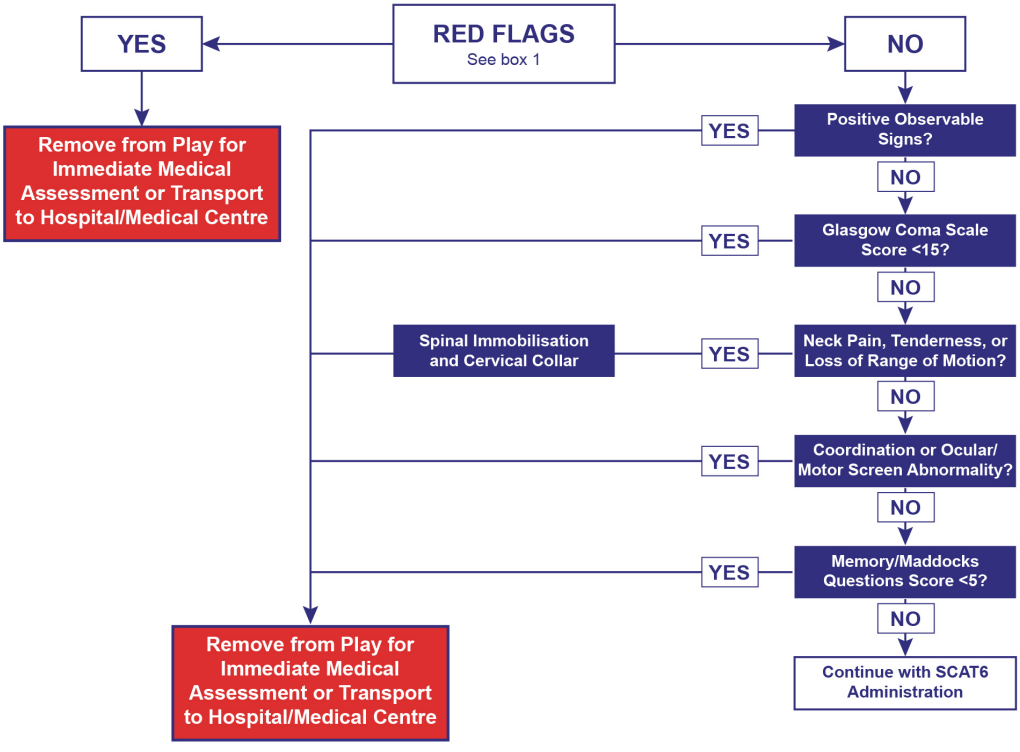
How long was the recovery (time to being cleared to play) from the most recent concussion?: **(Days)**

Immediate Assessment/Neuro Screen (Not Required at Baseline)

The following elements should be used in the evaluation of all athletes who are suspected of having a concussion prior to proceeding to the cognitive assessment, and ideally should be completed "on-field" after the first aid/emergency care priorities are completed.

If any of the observable signs of concussion are noted after a direct or indirect blow to the head, the athlete should be immediately and safely removed from participation and evaluated by an HCP.

The Glasgow Coma Scale is important as a standard measure for all patients and can be repeated over time to monitor deterioration of consciousness. The Maddocks questions and cervical spine exam are also critical steps of the immediate assessment.



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Step 1: Observable Signs

Witnessed ☐ Observed on Video ☐

Lying motionless on playing surface	Y	N
Falling unprotected to the surface	Y	N
Balance/gait difficulties, motor incoordination, ataxia: stumbling, slow/laboured movements	Y	N
Disorientation or confusion, staring or limited responsiveness, or an inability to respond appropriately to questions	Y	N
Blank or vacant look	Y	N
Facial injury after head trauma	Y	N
Impact seizure	Y	N
High-risk mechanism of injury (sport-dependent)	Y	N

Step 2: Glasgow Coma Scale

Typically, GCS is assessed once. Additional scoring columns are provided for monitoring over time, if needed.

Time of Assessment:

Date of Assessment:

Best Eye Response (E)			
No eye opening	1	1	1
Eye opening to pain	2	2	2
Eye opening to speech	3	3	3
Eyes opening spontaneously	4	4	4
Best Verbal Response (V)			
No verbal response	1	1	1
Incomprehensible sounds	2	2	2
Inappropriate words	3	3	3
Confused	4	4	4
Oriented	5	5	5
Best Motor Response (V)			
No motor response	1	1	1
Extension to pain	2	2	2
Abnormal flexion to pain	3	3	3
Flexion/withdrawal to pain	4	4	4
Localized to pain	5	5	5
Obeys commands	6	6	6
Glasgow Coma Score (E + V + M)			

Box 1: Red Flags

- Neck pain or tenderness
- Seizure or convulsion
- Double vision
- Loss of consciousness
- Weakness or tingling/burning in more than 1 arm or in the legs
- Deteriorating conscious state
- Vomiting
- Severe or increasing headache
- Increasingly restless, agitated or combative
- GCS <15
- Visible deformity of the skull

Step 3: Cervical Spine Assessment

In a patient who is not lucid or fully conscious, a cervical spine injury should be assumed and spinal precautions taken.

Does the athlete report neck pain at rest?	Y	N
Is there tenderness to palpation?	Y	N
If NO neck pain and NO tenderness, does the athlete have a full range of ACTIVE pain free movement?	Y	N
Are limb strength and sensation normal?	Y	N

Step 4: Coordination & Ocular/Motor Screen

Coordination: Is finger-to-nose normal for both hands with eyes open and closed?	Y	N
Ocular/Motor: Without moving their head or neck, can the patient look side-to-side and up-and-down without double vision?	Y	N
Are observed extraocular eye movements normal? If not, describe:	Y	N

Step 5: Memory Assessment Maddocks Questions[1]

Say *"I am going to ask you a few questions, please listen carefully and give your best effort. First, tell me what happened?"*

Modified Maddocks questions (Modified appropriately for each sport; 1 point for each correct answer)

What venue are we at today?	0	1
Which half is it now?	0	1
Who scored last in this match?	0	1
What team did you play last week/game?	0	1
Did your team win the last game?	0	1
Maddocks Score		/5

Note: Appropriate sport-specific questions may be substituted

For use by Health Care Professionals only

Sport Concussion Assessment Tool 6 - SCAT6™

Off-Field Assessment

Please note that the cognitive assessment should be done in a distraction-free environment with the athlete in a resting state **after** completion of the Immediate Assessment/Neuro Screen.

Step 1: Athlete Background

Has the athlete ever been:

Hospitalised for head injury? (If yes, describe below)	Y	N	Diagnosed with attention deficit hyperactivity disorder (ADHD)?	Y	N
Diagnosed/treated for headache disorder or migraine?	Y	N	Diagnosed with depression, anxiety, or other psychological disorder?	Y	N
Diagnosed with a learning disability/dyslexia?	Y	N			

Notes:

Current medications? If yes, please list:

Step 2: Symptom Evaluation

Baseline: ☐ **Suspected/Post-injury:** ☐ **Time elapsed since suspected injury:** _____ mins/hours/days

The athlete will complete the symptom scale (below) after you provide instructions. Please note that the instructions are different for baseline versus suspected/post-injury evaluations.

Baseline: Say ***"Please rate your symptoms below based on how you typically feel with "1" representing a very mild symptom and "6" representing a severe symptom."***

Suspected/Post-injury: Say ***"Please rate your symptoms below based on how you feel now with "1" representing a very mild symptom and "6" representing a severe symptom."***

PLEASE HAND THE FORM TO THE ATHLETE

Symptom	Rating
Headaches	0 1 2 3 4 5 6
Pressure in head	0 1 2 3 4 5 6
Neck pain	0 1 2 3 4 5 6
Nausea or vomiting	0 1 2 3 4 5 6
Dizziness	0 1 2 3 4 5 6
Blurred vision	0 1 2 3 4 5 6
Balance problems	0 1 2 3 4 5 6
Sensitivity to light	0 1 2 3 4 5 6
Sensitivity to noise	0 1 2 3 4 5 6
Feeling slowed down	0 1 2 3 4 5 6
Feeling like "in a fog"	0 1 2 3 4 5 6
"Don't feel right"	0 1 2 3 4 5 6
Difficulty concentrating	0 1 2 3 4 5 6
Difficulty remembering	0 1 2 3 4 5 6
Fatigue or low energy	0 1 2 3 4 5 6
Confusion	0 1 2 3 4 5 6
Drowsiness	0 1 2 3 4 5 6
More emotional	0 1 2 3 4 5 6
Irritability	0 1 2 3 4 5 6
Sadness	0 1 2 3 4 5 6
Nervous or anxious	0 1 2 3 4 5 6
Trouble falling asleep (if applicable)	0 1 2 3 4 5 6

Do your symptoms get worse with physical activity?	Y	N
Do your symptoms get worse with mental activity?	Y	N

If 100% is feeling perfectly normal, what percent of normal do you feel?

If not 100%, why?

PLEASE HAND THE FORM BACK TO THE EXAMINER

Once the athlete has completed answering all symptom items, it may be useful for the clinician to revisit items that were endorsed positively to gather more detail about each symptom.

Total number of symptoms: _____ **of 22** **Symptom severity score:** _____ **of 132**

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Step 3: Cognitive Screening (Based on Standardized Assessment of Concussion; SAC)[2]

Orientation

What month is it?	0	1
What is the date today?	0	1
What is the day of the week?	0	1
What year is it?	0	1
What time is it right now? (within 1 hour)	0	1
Orientation Score		of 5

Immediate Memory

All 3 trials must be administered irrespective of the number correct on Trial 1. Administer at the rate of one word per second.

Trial 1: Say *"I am going to test your memory. I will read you a list of words and when I am done, repeat back as many words as you can remember, in any order."*

Trials 2 and 3: Say *"I am going to repeat the same list. Repeat back as many words as you can remember in any order, even if you said the word before in a previous trial."*

Word list used: A ☐ B ☐ C ☐

				Alternate Lists	
List A	**Trial 1**	**Trial 2**	**Trial 3**	**List B**	**List C**
Jacket	0 1	0 1	0 1	Finger	Baby
Arrow	0 1	0 1	0 1	Penny	Monkey
Pepper	0 1	0 1	0 1	Blanket	Perfume
Cotton	0 1	0 1	0 1	Lemon	Sunset
Movie	0 1	0 1	0 1	Insect	Iron
Dollar	0 1	0 1	0 1	Candle	Elbow
Honey	0 1	0 1	0 1	Paper	Apple
Mirror	0 1	0 1	0 1	Sugar	Carpet
Saddle	0 1	0 1	0 1	Sandwich	Saddle
Anchor	0 1	0 1	0 1	Wagon	Bubble
Trial Total					

Immediate Memory Score ____ of 30 **Time Last Trial Completed:** ____

Step 3: Cognitive Screening (Continued)

Concentration

Digits Backward:

Administer at the rate of one digit per second reading DOWN the selected column. If a string is completed correctly, move on to the string with next higher number of digits; if the string is completed incorrectly, use the alternate string with the same number of digits; if this is failed again, end the test.

Say ***"I'm going to read a string of numbers and when I am done, you repeat them back to me in reverse order of how I read them to you. For example, if I say 7-1-9, you would say 9-1-7. So, if I said 9-6-8 you would say? (8-6-9)"***

Digit list used: A ☐ B ☐ C ☐

List A	List B	List C			
4-9-3	5-2-6	1-4-2	Y	N	
6-2-9	4-1-5	6-5-8	Y	N	0 1
3-8-1-4	1-7-9-5	6-8-3-1	Y	N	
3-2-7-9	4-9-6-8	3-4-8-1	Y	N	0 1
6-2-9-7-1	4-8-5-2-7	4-9-1-5-3	Y	N	
1-5-2-8-6	6-1-8-4-3	6-8-2-5-1	Y	N	0 1
7-1-8-4-6-2	8-3-1-9-6-4	3-7-6-5-1-9	Y	N	
5-3-9-1-4-8	7-2-4-8-5-6	9-2-6-5-1-4	Y	N	0 1
			Digits Score		of 4

Months in Reverse Order:

Say ***"Now tell me the months of the year in reverse order as QUICKLY and as accurately as possible. Start with the last month and go backward. So, you'll say December, November… go ahead"***

Start stopwatch and CIRCLE each correct response:

December November October September August July June May April March February January

Time Taken to Complete (secs): _____ **Number of Errors:** _____

1 point if no errors and completion under 30 seconds

Months Score: _____ **of 1**

Concentration Score (Digits + Months)	of 5

Step 4: Coordination and Balance Examination

Modified Balance Error Scoring System (mBESS)[3] testing

(see detailed administration instructions)

Foot Tested: **Left** ☐ **Right** ☐ (i.e. test the **non-dominant** foot)

Testing Surface (hard floor, field, etc.): _____

Footwear (shoes, barefoot, braces, tape etc.): _____

OPTIONAL (depending on clinical presentation and setting resources): For further assessment, the same 3 stances can be performed on a surface of medium density foam (e.g., approximately 50cm x 40cm x 6cm) with the same instructions and scoring.

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British Journal of Sports Medicine

Step 4: Coordination and Balance Examination (Continued)

Modified BESS

(20 seconds each)

Double Leg Stance:		**of 10**
Tandem Stance:		**of 10**
Single Leg Stance:		**of 10**
Total Errors:		**of 30**

On Foam (Optional)

Double Leg Stance:		**of 10**
Tandem Stance:		**of 10**
Single Leg Stance:		**of 10**
Total Errors:		**of 30**

Note: If the **mBESS** yields normal findings then proceed to the **Tandem Gait/Dual Task Tandem Gait**.

If the **mBESS** reveals abnormal findings or clinically significant difficulties, **Tandem Gait** is not necessary at this time.

Both the **Tandem Gait** and optional **Dual Task** component may be administered later in the office setting as needed (see SCOAT6).

Timed Tandem Gait

Place a 3-metre-long line on the floor/firm surface with athletic tape. The task should be timed. Please complete all 3 trials.

Say ***"Please walk heel-to-toe quickly to the end of the tape, turn around and come back as fast as you can without separating your feet or stepping off the line."***

Single Task:

Time to Complete Tandem Gait Walking (seconds)				
Trial 1	**Trial 2**	**Trial 3**	**Average 3 Trials**	**Fastest Trial**

Dual Task Gait (Optional. Timed Tandem Gait must be completed first)

Place a 3-metre-long line on the floor/firm surface with athletic tape. The task should be timed.

Say ***"Now, while you are walking heel-to-toe, I will ask you to count backwards out loud by 7s. For example, if we started at 100, you would say 100, 93, 86, 79. Let's practise counting. Starting with 93, count backward by sevens until I say "stop"."*** Note that this practice only involves counting backwards.

Dual Task Practice: Circle correct responses; record number of subtraction counting errors.

Task									Errors	Time
Practice	**93**	**86**	**79**	**72**	**65**	**58**	**51**	**44**		

Say ***"Good. Now I will ask you to walk heel-to-toe and count backwards out loud at the same time. Are you ready? The number to start with is 88. Go!"***

Dual Task Cognitive Performance: Circle correct responses; record number of subtraction counting errors.

Task													Errors	Time (circle fastest)
Trial 1	**88**	**81**	**74**	**67**	**60**	**53**	**46**	**39**	**32**	**25**	**18**	**11**	**4**		
Trial 2	**90**	**83**	**76**	**69**	**62**	**55**	**48**	**41**	**34**	**27**	**20**	**13**	**6**		
Trial 3	**98**	**91**	**84**	**77**	**70**	**63**	**56**	**49**	**42**	**35**	**28**	**21**	**14**		

Alternate double number starting integers may be used and recorded below.

Starting Integer: **Errors:** **Time:**

Step 4: Coordination and Balance Examination (Continued)

Were any single- or dual-task, timed tandem gait trials not completed due to walking errors or other reasons?

Yes ☐ **No** ☐

If yes, please explain why:

Step 5: Delayed Recall

The Delayed Recall should be performed after **at least 5 minutes** have elapsed since the end of the Immediate Memory section: **Score 1 point for each correct response.**

Say ***"Do you remember that list of words I read a few times earlier? Tell me as many words from the list as you can remember in any order."***

Time started:

Word list used: **A** ☐ **B** ☐ **C** ☐

		Alternate Lists	
List A	**Score**	**List B**	**List C**
Jacket	0 1	Finger	Baby
Arrow	0 1	Penny	Monkey
Pepper	0 1	Blanket	Perfume
Cotton	0 1	Lemon	Sunset
Movie	0 1	Insect	Iron
Dollar	0 1	Candle	Elbow
Honey	0 1	Paper	Apple
Mirror	0 1	Sugar	Carpet
Saddle	0 1	Sandwich	Saddle
Anchor	0 1	Wagon	Bubble
Delayed Recall Score	of 10		

Total Cognitive Score

Orientation:		**of 5**
Immediate Memory:		**of 30**
Concentration:		**of 5**
Delayed Recall:		**of 10**
Total:		**of 50**

If the athlete was known to you prior to their injury, are they different from their usual self?

Yes ☐ **No** ☐ **Not applicable** ☐ (If different, describe why In the clinical notes section)

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Step 6: Decision

Domain	Date:	Date:	Date:
Neurological Exam (Acute Injury evaluation only)	Normal/Abnormal	Normal/Abnormal	Normal/Abnormal
Symptom number (of 22)			
Symptom Severity (of 132)			
Orientation (of 5)			
Immediate Memory (of 30)			
Concentration (of 5)			
Delayed Recall (of 10)			
Cognitive Total Score (of 50)			
mBESS Total Errors (of 30)			
Tandem Gait fastest time			
Dual Task fastest time			

Disposition

Concussion diagnosed?

Yes ☐ **No** ☐ **Deferred** ☐

Health Care Professional Attestation

I am an HCP and I have personally administered or supervised the administration of this SCAT6.

Name:

Signature: **Title/Speciality:**

Registration/License number (if applicable): **Date:**

Additional Clinical Notes

Note: Scoring on the SCAT6 should not be used as a stand-alone method to diagnose concussion, measure recovery, or make decisions about an athlete's readiness to return to sport after concussion. Remember: An athlete can score within normal limits on the SCAT6 and still have a concussion.

CRT6™

Concussion Recognition Tool

To Help Identify Concussion in Children, Adolescents and Adults

What is the Concussion Recognition Tool?

A concussion is a brain injury. The Concussion Recognition Tool 6 (CRT6) is to be used by non-medically trained individuals for the identification and immediate management of suspected concussion. It is not designed to diagnose concussion.

Recognise and Remove

Red Flags: CALL AN AMBULANCE

If **ANY** of the following signs are observed or complaints are reported after an impact to the head or body the athlete should be immediately removed from play/game/activity and transported for urgent medical care by a healthcare professional (HCP):

- **Neck pain or tenderness**
- **Seizure, 'fits', or convulsion**
- **Loss of vision or double vision**
- **Loss of consciousness**
- **Increased confusion or deteriorating conscious state (becoming less responsive, drowsy)**
- **Weakness or numbness/tingling in more than one arm or leg**
- **Repeated Vomiting**
- **Severe or increasing headache**
- **Increasingly restless, agitated or combative**
- **Visible deformity of the skull**

Remember

- In all cases, the basic principles of first aid should be followed: assess danger at the scene, check airway, breathing, circulation; look for reduced awareness of surroundings or slowness or difficulty answering questions.
- Do not attempt to move the athlete (other than required for airway support) unless trained to do so.
- Do not remove helmet (if present) or other equipment.
- Assume a possible spinal cord injury in all cases of head injury.
- Athletes with known physical or developmental disabilities should have a lower threshold for removal from play.

If there are no Red Flags, identification of possible concussion should proceed as follows:

Concussion should be suspected after an impact to the head or body when the athlete seems different than usual. Such changes include the presence of **any one or more** of the following: visible clues of concussion, signs and symptoms (such as headache or unsteadiness), impaired brain function (e.g. confusion), or unusual behaviour.

CRT6™

Developed by: The Concussion in Sport Group (CISG)

Supported by:

International Olympic Committee · FEI · FIA · FIFA · IIHF · World Rugby

CRT6 Concussion Recognition Tool

To Help Identify Concussion in Children, Adolescents and Adults

1: Visible Clues of Suspected Concussion

Visible clues that suggest concussion include:

- Loss of consciousness or responsiveness
- Lying motionless on the playing surface
- Falling unprotected to the playing surface
- Disorientation or confusion, staring or limited responsiveness, or an inability to respond appropriately to questions
- Dazed, blank, or vacant look
- Seizure, fits, or convulsions
- Slow to get up after a direct or indirect hit to the head
- Unsteady on feet / balance problems or falling over / poor coordination / wobbly
- Facial injury

2: Symptoms of Suspected Concussion

Physical Symptoms
Headache
"Pressure in head"
Balance problems
Nausea or vomiting
Drowsiness
Dizziness
Blurred vision
More sensitive to light
More sensitive to noise
Fatigue or low energy
"Don't feel right"
Neck Pain

Changes in Emotions
More emotional
More Irritable
Sadness
Nervous or anxious

Changes in Thinking
Difficulty concentrating
Difficulty remembering
Feeling slowed down
Feeling like "in a fog"

Remember, symptoms may develop over minutes or hours following a head injury.

3: Awareness

(Modify each question appropriately for each sport and age of athlete)

Failure to answer any of these questions correctly may suggest a concussion:

"Where are we today?"

"What event were you doing?"

"Who scored last in this game?"

"What team did you play last week/game?"

"Did your team win the last game?"

Any athlete with a suspected concussion should be - IMMEDIATELY REMOVED FROM PRACTICE OR PLAY and should NOT RETURN TO ANY ACTIVITY WITH RISK OF HEAD CONTACT, FALL OR COLLISION, including SPORT ACTIVITY until ASSESSED MEDICALLY, even if the symptoms resolve.

Athletes with suspected concussion should **NOT**:

- Be left alone initially (at least for the first 3 hours). Worsening of symptoms should lead to immediate medical attention.
- Be sent home by themselves. They need to be with a responsible adult.
- Drink alcohol, use recreational drugs or drugs not prescribed by their HCP
- Drive a motor vehicle until cleared to do so by a healthcare professional

British Journal of Sports Medicine

Appendix 2d: Headcase Pitch-side Cards for School Nurse and PE staff

RED FLAGS

Reported or observed 'red flags' could indicate a potentially more serious head injury. They include:

- Loss of consciousness due to injury
- Deteriorating consciousness
- Increasing confusion or irritability
- Double vision
- Seizure or convulsion
- Repeated vomiting
- Severe neck pain

The full list of Red Flags are in the **Extended Guidelines** in the HEADCASE toolkit.

If ANY of the 'red flags' are present, the player should receive urgent medical assessment from an appropriate Healthcare Professional onsite or at an A&E Hospital Dept, via emergency ambulance transfer if necessary.

RECOVER & RETURN

Graduated Return to Activity & Sport (GRAS) programme

STAGE 1: Initial Relative Rest
24 - 48 hours after concussion

STAGE 2: Return to Daily Activities & Light Physical Activities
Following **24 - 48 hours** initial rest period (min 24 hours after concussion event)

STAGE 3: Aerobic Exercise & Low Level Body Weight Resistance Training
When symptoms allow e.g., mild symptoms are not worsened by daily activities/light physical activities

STAGE 4: Rugby-Specific Non-Contact Training Drills & Weight Resistance Training
No earlier than **Day 8**

STAGE 5: Full Contact Practice
No earlier than **Day 15**

STAGE 6: Return to Play
No earlier than **Day 21**

RECOGNISE, REMOVE and

If in doubt, sit them out!

HEADCASE

STOP!

Check for concussion

RECOGNISING CONCUSSION

Priority is to **RECOGNISE & REMOVE** anyone with suspected concussion. Concussion should be suspected if one or more of the following visual clues and signs, symptoms are present.

VISUAL CLUES & SIGNS
(What you can see)

Any one of the following can indicate a possible concussion:

- Loss of consciousness or responsiveness
- Lying motionless on ground / Slow to get up
- Unsteady on feet / Balance problems or falling over / Incoordination
- Grabbing / Clutching of head
- Dazed, blank or vacant look
- Confused / Not aware of plays or events

SYMPTOMS OF CONCUSSION AT OR SHORTLY AFTER INJURY
(What the player might tell you / what you should ask about)

Presence of any one of the following can indicate a possible concussion:

- Loss of consciousness
- Headache, or "Pressure in head"
- Seizure or convulsion
- Dizziness or balance problems
- Confusion
- Difficulty concentrating or feeling like "in a fog"
- Nausea or vomiting
- Drowsiness, feeling slowed down, fatigue or low energy
- More emotional or sadness
- Blurred vision, or sensitivity to light or noise
- Nervous, anxious or irritable
- Difficulty remembering or amnesia
- Neck Pain
- "Don't feel right"

THE IMMEDIATE DOS AND DON'TS FOLLOWING A SUSPECTED CONCUSSION

DO

- Be removed from play immediately.
- Get assessed by an appropriate Healthcare Professional onsite or access the NHS by calling 111 within 24 hours of the incident.
- Rest & sleep as needed for the first 24-48 hours – this is good for recovery. Easy activities of daily living and walking are also acceptable.
- Minimise smartphone, screen and computer use for at least the first 48 hours. Limiting screen-time has been shown to improve recovery.

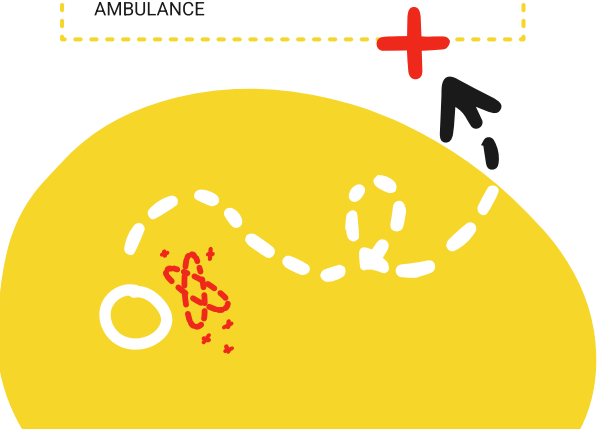
DO NOT

- Be left alone in the first 24 hours.
- Consume alcohol in the first 24 hours and/or if symptoms persist.
- Drive a motor vehicle within the first 24 hours *(Commercial drivers (HGV etc.) should seek review by an appropriate Healthcare Professional before driving).*

FIRST AID

Remember, in all cases, the basic principles of first aid should be followed:

- Safe approach
- Do not move the player until safe to do so
- Apply basic first aid principles first and check airway, breathing, and circulation
- Assess for spinal injury
- Do not remove headgear if a neck injury is suspected unless trained to do so
- If any danger signs DIAL 999 and CALL AN AMBULANCE



Head injury and concussion

Most head injuries are not serious, but you should get medical help if you or your child have any symptoms after a head injury. You might have concussion (temporary brain injury) that can last a few weeks.

Go to A&E if:

You or your child have had a head injury and have:

- been knocked out but have now woken up
- vomited (been sick) since the injury
- a headache that does not go away with painkillers
- a change in behaviour, like being more irritable or losing interest in things around you (especially in children under 5)
- been crying more than usual (especially in babies and young children)
- problems with memory
- been drinking alcohol or taking drugs just before the injury
- a blood clotting disorder (like haemophilia) or you take medicine to thin your blood
- had brain surgery in the past

You or your child could have concussion. Symptoms usually start within 24 hours, but sometimes may not appear for up to 3 weeks.

You should also go to A&E if you think someone has been injured intentionally.

Find your nearest A&E (Link: https://www.nhs.uk/Service-Search/Accident-and-emergency-services/LocationSearch/428)

Call 999 if:

Someone has hit their head and has:

- been knocked out and has not woken up
- difficulty staying awake or keeping their eyes open
- a fit (seizure)
- fallen from a height more than 1 metre or 5 stairs
- problems with their vision or hearing
- a black eye without direct injury to the eye
- clear fluid coming from their ears or nose
- bleeding from their ears or bruising behind their ears
- numbness or weakness in part of their body
- problems with walking, balance, understanding, speaking or writing
- hit their head at speed, such as in a car crash, being hit by a car or bike or a diving accident
- a head wound with something inside it or a dent to the head

Also call 999 if you cannot get someone to A&E safely.

Help from NHS 111

If you're not sure what to do, call 111 or get help from 111 online (Link: https://111.nhs.uk/).

NHS 111 can tell you the right place to get help.

How to care for a minor head injury

If you have been sent home from hospital with a minor head injury, or you do not need to go to hospital, you can usually look after yourself or your child at home.

You might have symptoms of concussion, such as a slight headache or feeling sick or dazed, for up to 2 weeks.

Do

- ✔ hold an ice pack (or a bag of frozen peas in a tea towel) to the area regularly for short periods in the first few days to bring down any swelling
- ✔ rest and avoid stress – you or your child do not need to stay awake if you're tired
- ✔ take painkillers such as paracetamol (Link:) for headaches
- ✔ make sure an adult stays with you or your child for at least the first 24 hours

Don’t

- ✘ do not go back to work or school until you're feeling better
- ✘ do not drive until you feel you have fully recovered
- ✘ do not play contact sports for at least 3 weeks – children should avoid rough play for a few days
- ✘ do not take drugs or drink alcohol until you're feeling better
- ✘ do not take sleeping pills while you're recovering unless a doctor advises you to

See a GP if:

- your or your child's symptoms last more than 2 weeks
- you're not sure if it's safe for you to drive or return to work, school or sports

Page last reviewed: 26 October 2021
Next review due: 26 October 2024

UK Government

IF IN DOUBT, SIT THEM OUT

UK Concussion Guidelines for Non-Elite (Grassroots) Sport

April 2023

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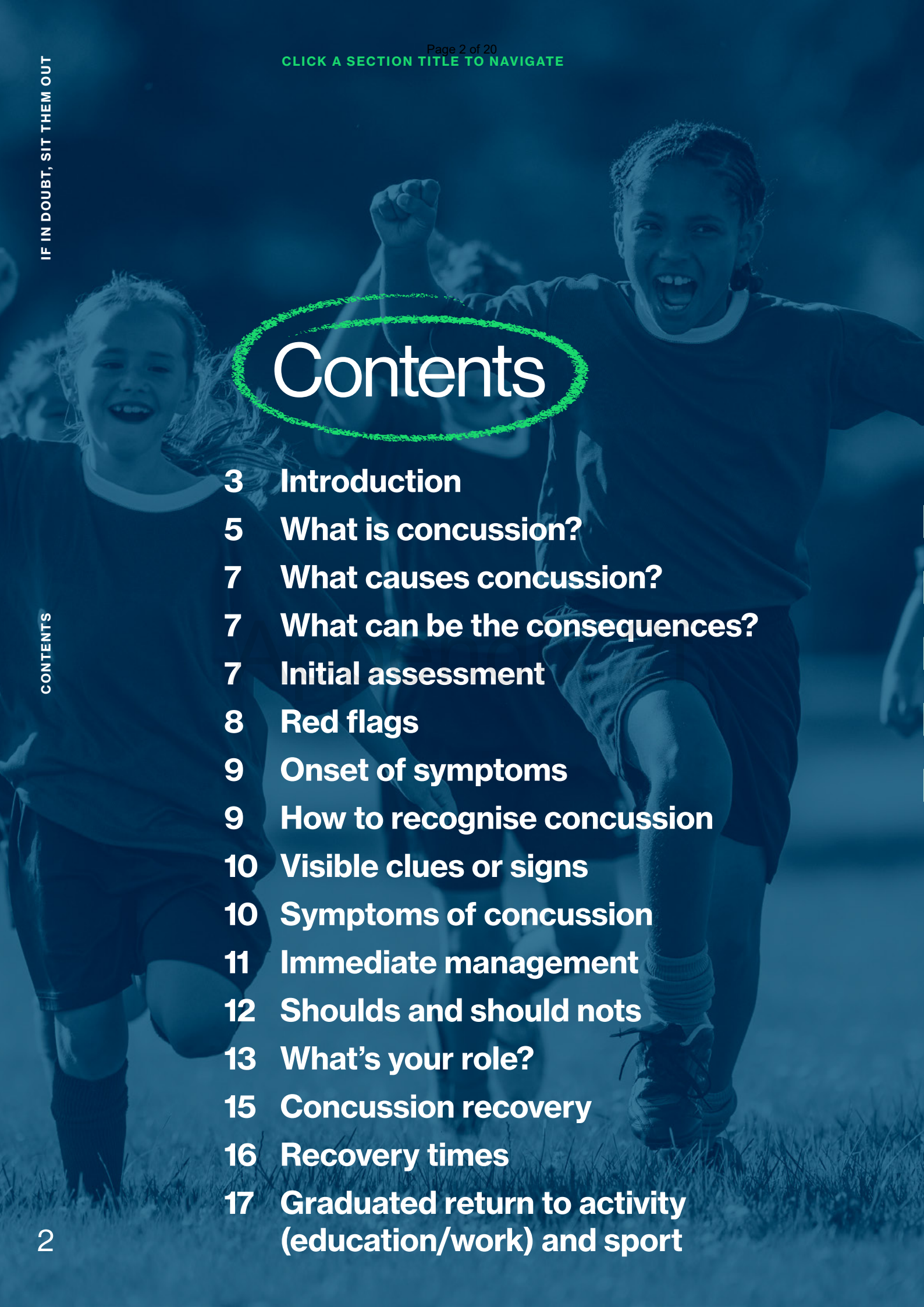

Contents

Introduction

The following guidance is intended to provide information on how to recognise concussion and on how it should be managed from the time of injury through to a safe return to education, work and playing sport.

This information is intended for the general public and for individuals participating in all grassroots sports – primary school age and upwards - where Healthcare Professionals are typically not available onsite to manage concussed individuals.

This document contains general medical information, but this does not constitute medical advice and should not be relied on as such. Nor is this guidance a substitute for medical advice from a qualified medical practitioner or healthcare provider. You must not rely on this guidance as an alternative to seeking medical advice from a qualified medical practitioner or healthcare provider. In particular, if you have any questions or concerns about a particular medical matter you should immediately consult a qualified medical practitioner or healthcare provider. If you think you may be suffering from a medical condition you should seek immediate medical attention. You should never delay seeking medical advice, disregard medical advice or discontinue medical treatment because of information contained in this guidance.

At all levels in all sports, if an individual is suspected of having a concussion, they must be immediately removed from play.

IF IN DOUBT, SIT THEM OUT

No-one should return to competition, training or Physical Education (PE) lessons within 24 hours of a suspected concussion. Anyone with a suspected concussion should NOT drive a motor vehicle (e.g. car or motorcycle), ride a bicycle, operate machinery, or drink alcohol within 24 hours of a suspected concussion and commercial drivers (HGV etc.) should seek review by an appropriate Healthcare Professional before driving.

All those suspected of sustaining a concussion should be assessed by an appropriate onsite Healthcare Professional or by accessing the NHS by calling 111 within 24 hours of the injury. If there are concerns about other significant injury or the presence of 'red flags' then the player should receive urgent medical assessment onsite or in a hospital Accident and Emergency (A&E) Department using ambulance transfer by calling 999 if necessary.

Anyone with concussion should generally rest for 24-48 hours but can undertake easy activities of daily living and walking, but must avoid intense exercise, challenging work, or sport. They can then progress through the graduated return to activity (education/work) and sport programme.

Anyone with symptoms that last longer than 28 days should be assessed and managed by an appropriate Healthcare Professional (e.g. their General Practitioner [GP])

Key points

- **Most people with concussion recover fully with time**.
- A concussion is a brain injury.
- All concussions are serious.
- Head injury can be fatal.
- Most concussions occur without loss of consciousness (being 'knocked out').
- Anyone with one or more visible clues, or symptoms of a head injury must be immediately removed from playing or training and must not take part in any further physical sport or work activity, even if symptoms resolve, until assessment by an appropriate Healthcare Professional or by accessing the NHS by calling 111, which should be sought within 24 hours.
- Return to education/work takes priority over return to sport.
- Individuals with concussion should only return to playing sport which risks head injury after having followed a graduated return to activity (education/work) and sport programme.
- All concussions should be managed individually, but there should be no return to competition **before** 21 days from injury.
- Anyone with symptoms after 28 days should seek medical advice from their GP (which may in turn require specialist referral and review).

What is concussion?

Concussion is a traumatic brain injury resulting in a disturbance of brain function. It affects the way a person thinks, feels and remembers things.

Loss of consciousness (being 'knocked out') occurs in less than 10% of concussions and is not required to diagnose concussion. However, anyone who loses consciousness because of a head injury has had a concussion.

Anyone with suspected concussion should be immediately removed from the field of play and assessed by an appropriate Healthcare Professional or access the NHS by calling 111 within 24 hours of the injury.

IF IN DOUBT, SIT THEM OUT

Concussion can affect people in four main areas,

Physical

e.g. headaches, dizziness, vision changes

Mental processing

e.g. not thinking clearly, feeling slowed down

Mood

e.g. short tempered, sad, emotional

Sleep

e.g. not being able to sleep or sleeping too much

There may be times when the person may have no visible signs such as looking blank and being off balance. It can be very difficult to differentiate concussion from other more serious injuries, such as bleeding in the brain. Other significant injuries such as injuries to the neck or face can also occur along with concussion.

Playing on with symptoms of concussion can make them worse, significantly delay recovery, and, should another head injury occur, result in more severe injury and in rare cases, death (known as second impact syndrome). This is why it is so important to remove anyone with suspected concussion from the at-risk activity immediately.

What causes concussion?

Concussion can be caused by a direct blow to the head but can also occur when knocks to other parts of the body result in rapid movement of the head (e.g. whiplash type injuries).

What can be the consequences of concussion?

A history of previous concussion(s) increases the risk of sustaining a further concussion, which may then take longer to recover.

A history of a recent concussion also increases the risk of other sport-related injuries (e.g. musculoskeletal injuries).

Concussions can happen at any age. However, children and adolescents:

- May be more susceptible to concussion.
- Take longer to recover and returning to education too early may exacerbate symptoms and prolong recovery.
- Are more susceptible to rare and dangerous neurological complications, including death caused by a second impact before recovering from a previous concussion.

Initial assessment

All those suspected of sustaining a concussion should be assessed by an appropriate onsite Healthcare Professional or by accessing the NHS by calling 111 within 24 hours of the injury. If there are concerns about other significant injury or the presence of 'red flags' then the player should receive urgent medical assessment onsite or in a hospital Accident and Emergency (A&E) Department using ambulance transfer by calling 999 if necessary.

Red flags – requiring urgent medical assessment

If any of the following 'red flags' are reported or observed, then the player should receive urgent medical assessment from an appropriate Healthcare Professional onsite or in a hospital Accident and Emergency (A&E) Department using emergency ambulance transfer if necessary:

- Any loss of consciousness because of the injury
- Deteriorating consciousness (more drowsy)
- Amnesia (no memory) for events before or after the injury
- Increasing confusion or irritability
- Unusual behaviour change
- Any new neurological deficit e.g.
  - Difficulties with understanding, speaking, reading or writing
  - Decreased sensation
  - Loss of balance
  - Weakness
  - Double vision
- Seizure/convulsion or limb twitching or lying rigid/ motionless due to muscle spasm
- Severe or increasing headache
- Repeated vomiting
- Severe neck pain
- Any suspicion of a skull fracture (e.g. cut, bruise, swelling, severe pain at site of injury)
- Previous history of brain surgery or bleeding disorder
- Current 'blood-thinning' therapy
- Current drug or alcohol intoxication

Onset of symptoms

The first symptoms of concussion typically appear immediately or within minutes of injury but may be delayed and appear over the first 24-48 hours following a head injury. Over the next several days, additional symptoms may become apparent (e.g. mood changes, sleep disorders, problems with concentration).

How to recognise a concussion

Spotting head impacts and visible clues of concussion can be difficult in fast moving sports. It is the responsibility of everyone – players, coaches, teachers, referees, spectators, and families – to watch out for individuals with suspected concussion and ensure that they are immediately removed from play. Continuing to play following a concussion is dangerous and leads to a longer recovery period.

Remember that the primary aim is to protect the individual from further injury by immediately removing them from play. Return to play should not be permitted until after evaluation by an appropriate Healthcare Professional and the successful completion of a graduated return to activity (education/work) and sport programme.

If any of the following visible clues or symptoms are present following a head injury, the player should be suspected of having a concussion and immediately removed from play or training and evaluated by an appropriate Healthcare Professional.

Visible clues (signs) of concussion

What you see

Any one or more of the following visible clues can indicate a concussion:

- Loss of consciousness or responsiveness
- Lying motionless on ground/slow to get up
- Unsteady on feet/balance problems or falling over/ incoordination
- Dazed, blank or vacant look
- Slow to respond to questions
- Confused/not aware of plays or events
- Grabbing/clutching of head
- An impact seizure/convulsion
- Tonic posturing – lying rigid/ motionless due to muscle spasm (may appear to be unconscious)
- More emotional/irritable than normal for that person
- Vomiting

Symptoms of concussion at or shortly after injury

What you are told/what you should ask about

Presence of any one or more of the following signs & symptoms may suggest a concussion:

- Disoriented (not aware of their surroundings e.g. opponent, period, score)
- Headache
- Dizziness/feeling off-balance
- Mental clouding, confusion or feeling slowed down
- Drowsiness/feeling like 'in a fog'/ difficulty concentrating
- Visual problems
- Nausea
- Fatigue
- 'Pressure in head'
- Sensitivity to light or sound
- More emotional
- Don't feel right
- Concerns expressed by parent, official, spectators about a player

Immediate management of a suspected concussion

Anyone with a suspected concussion should be **IMMEDIATELY REMOVED FROM PLAY**.

IF IN DOUBT, SIT THEM OUT

Once safely removed from play, the player must not be returned to activity that day and until an appropriate Healthcare Professional has excluded concussion or the patient has completed a graduated return to activity (education/work) and sport programme.

If a neck injury is suspected, the player should only be moved by Healthcare Professionals with appropriate training.

Teammates, coaches, match officials, team managers, administrators or parents/carers who suspect someone may have concussion MUST do their best to ensure that the individual is removed from play in as rapid and safe a manner as possible.

Anyone with a suspected concussion should:

- Be removed from play immediately.
- Get assessed by an appropriate Healthcare Professional onsite or access the NHS by calling 111 within 24 hours of the incident.
- Rest & sleep as needed for the first 24-48 hours – this is good for recovery. Easy activities of daily living and walking are also acceptable.
- Minimise smartphone, screen and computer use for at least the first 48 hours. Limiting screentime has been shown to improve recovery.

Anyone with a suspected concussion should not:

- Be left alone in the first 24 hours.
- Consume alcohol in the first 24 hours and/or if symptoms persist.
- Drive a motor vehicle within the first 24 hours. Commercial drivers (HGV etc.) should seek review by an appropriate Healthcare Professional before driving.

Following a suspected concussion, what's your role?

Coaches, teachers, volunteers

- Safely remove the individual from the field of play and ensure that they do not return to play in that game even if they say that their symptoms have resolved.
- Observe the player or assign a responsible adult to monitor the individual once the player is removed.
- If player is under 18 years old, contact parent/guardian to inform them of the possible concussion.
- Arrange for the player to get home safely.
- Arrange for a responsible adult to supervise the player over the next 24-48 hours.
- Ensure any relevant injury report form is completed and stored by the club/school/organisation.
- Follow a graduated return to activity (education/work) and sport programme with an emphasis on initial relative rest and returning to education/work before returning to training for sport.

Parents, carers

- Obtain full details of the incident.
- Do not leave your child alone for the first 24 hours.
- Have your child assessed by an appropriate Healthcare Professional onsite within 24 hours or by accessing the NHS by calling 111.
- Monitor your child for worsening signs and symptoms of concussion for at least 24-48 hours.
- Encourage initial rest/sleep as needed and limit smartphone/computer and screen use for the first 24-48 hours.
- Inform school/work/other sports clubs of the suspected concussion.
- Support your child to follow a graduated return to activity (education/work) and sport programme.

Players

- Stop playing/training **immediately** if you experience any symptoms of concussion.
- Be honest with how you feel and report any symptoms immediately to your coach, medic and/or parent.
- Delays in reporting and under-reporting of symptoms have been associated with a longer recovery and delayed return to activity and could risk incomplete recovery of the brain.
- If you have continuing symptoms, do not return to training or sport activities until evaluated by an appropriate Healthcare Professional.
- Inform your school/work/sports clubs.
- Follow the graduated return to activity (education/work) and sport programme.
- During training and matches always watch out for teammates and encourage them to be honest and report any concussion symptoms.
- If you question whether another player may have symptoms of concussion, report this to the coach, match official or appropriate Healthcare Professional.

Concussion recovery

The graduated return to activity (education/work) and sport programme

Generally, a short period of relative rest (24-48 hours) followed by a gradual stepwise return to normal life and then subsequently sport is the cornerstone of concussion management. In the first 24-48 hours, it is ok to perform mental activities like reading, and activities of daily living as well as walking.

After initial assessment and confirmation of concussion by an appropriate Healthcare Professional onsite or via NHS by calling 111, the graduated return to activity (education/work) and sport programme typically can be self-managed, although severe or prolonged symptoms (over 28 days) should be under the supervision of an appropriate Healthcare Professional and management will depend on the severity of symptoms and the types of symptoms and difficulties that are present. This varies from person to person and is not a 'one size fits all' process.

After a 24-48 hour period of relative rest, a staged return to normal life (education/work) and sport at a rate that does not exacerbate existing symptoms, more than mildly, or produce new symptoms is the main aim. This is before return to sport is contemplated.

It is acceptable to allow students to return to school or work activities, and subsequently school or work part-time (e.g. half-days or with scheduled breaks), even if symptoms are still present, provided that symptoms are not severe or significantly worsened. The final stage of return to school or work activity is when the individual is back to full pre-injury mental activity, and this should occur before return to unrestricted sport is contemplated.

Similar to the return to education/work progression, the return to sport progression can occur at a rate that does not, more than mildly, exacerbate existing symptoms or produce new symptoms. It is acceptable to begin light aerobic activity (e.g. walking, light jogging, riding a stationary bike etc.), even if symptoms are still present, provided they are stable and are not getting worse and the activity is stopped for more than mild symptom exacerbation. Symptom exacerbations are typically brief (several minutes to a few hours) and the activity can be resumed once the symptom exacerbation has subsided.

Although symptoms may resolve following a concussion, it takes longer for the brain to recover. The aim is to:

Rehabilitate the person – give the brain time to recover

Concussion recovery time varies

Most symptoms of a concussion resolve by two to four weeks, but some can take longer. Everyone is unique in their recovery duration which is why completion of a graduated return to activity (education/work) and sport programme is important to reduce the risks of a slow recovery, further brain injury, and longer-term problems. Children and adolescents may take longer to recover than adults.

If symptoms persist for more than 28 days, individuals need to be assessed by an appropriate Healthcare Professional – typically their GP.

Please note that headaches can persist for several months or more, well after the acute injury from the concussion has resolved. They may resemble migraine and may be associated with nausea and sensitivity to light and/or sound. Sometimes they are from a neck injury. Persisting symptoms are not usually due to a more severe brain injury and, if the headache is not increased by mental or physical activity and the frequency and intensity is managed adequately, it should not preclude an individual from returning to school, work and physical activity.

Graduated return to activity (education/work) and sport

Overview

- Generally, a short period of relative rest (first 24-48 hours) followed by a gradual stepwise return to normal life (education, work, low level exercise), then subsequently to sport is safe and effective.
- Progression through the stages below is dependent upon the activity not more than mildly exacerbating symptoms. Medical advice from the NHS via 111 should be sought if symptoms deteriorate or do not improve by 14 days after the injury. Those with symptoms after 28 days should seek medical advice via their GP.
- Participating in light physical activity is beneficial and has been shown to have a positive effect on recovery after the initial period of relative rest. The focus should be on returning to normal daily activities of education and work in advance of unrestricted sporting activities.

If symptoms continue beyond 28 days remain out of sport and seek medical advice from a GP

Notes

- The graduated return to activity (education/work) and sport programme is designed to safely allow return to education, work and sport after concussion for the overwhelming majority of athletes who will not benefit from individualised management of their recovery.
- Some athletes, as happens in Elite and Professional sport, may have access to Healthcare Professionals experienced in sports concussion management who take responsibility for an individualised, structured, multimodal, multidisciplinary management plan to include medical, psychological, cognitive, vestibular and musculoskeletal components. Athletes who are managed in such Enhanced Care pathways may be formally cleared for an earlier return to competition.

GRADUATED RETURN TO EDUCATION/WORK & SPORT SUMMARY

(See full table below for detail)

Stage 1	**Relative Rest for 24–48 hours** • Minimise screen time • Gentle exercise*
Stage 2	**Gradually introduce daily activities** • Activities away from school/work (introduce TV, increase reading, games etc)* • Exercise –light physical activity (e.g. short walks) *
Stage 3	**Increase tolerance for mental & exercise activities** • Increase study/work-related activities with rest periods* • Increase intensity of exercise*
Stage 4	**Return to study/work and sport training** • Part-time return to education/work* • Start training activities without risk of head impact*
Stage 5	**Return to normal work/education and full training** • Full work/education • If symptom-free at rest for 14 days consider full training
Stage 6	**Return to sports competition (NOT before day 21) as long as symptom free at rest for 14 days and during the pre-competition training of Stage 5**

*rest until the following day if this activity more than mildly increases symptoms.

Graduated return to activity (education/work) and sport programme

Stage	Focus	Description of activity	Comments
Stage 1	**Relative rest period (24-48 hours)**	Take it easy for the first 24-48 hours after a suspected concussion. It is best to minimise any activity to 10 to 15-minute slots. You may walk, read and do some easy daily activities provided that your concussion symptoms are no more than mildly increased. Phone or computer screen time should be kept to the absolute minimum to help recovery.	
Stage 2	**Return to normal daily activities outside of school or work.**	• Increase mental activities through easy reading, limited television, games, and limited phone and computer use. • Gradually introduce school and work activities at home. • Advancing the volume of mental activities can occur as long as they do not increase symptoms more than mildly.	There may be some mild symptoms with activity, which is OK. If they become more than mildly exacerbated by the mental or physical activity in Stage 2, rest briefly until they subside.
	Physical Activity (e.g. week 1)	• After the initial 24–48 hours of relative rest, gradually increase light physical activity. • Increase daily activities like moving around the house, simple chores and short walks. Briefly rest if these activities more than mildly increase symptoms.	
Stage 3	**Increasing tolerance for thinking activities**	• Once normal level of daily activities can be tolerated then explore adding in some home-based school or work-related activity, such as homework, longer periods of reading or paperwork in 20 to 30-minute blocks with a brief rest after each block. • Discuss with school or employer about returning part-time, time for rest or breaks, or doing limited hours each week from home	Progressing too quickly through stages 3 - 5 whilst symptoms are significantly worsened by exercise may slow recovery. Although headaches are the most common symptom following concussion and may persist for several months, exercise should be limited to that which does not more than mildly exacerbate them. Symptom exacerbation with physical activity and exercise is generally safe, brief and is self-limiting typically lasting from several minutes to a few hours.
	Light aerobic exercise (e.g. weeks 1 or 2)	• Walking or stationary cycling for 10–15 minutes. Start at an intensity where able to easily speak in short sentences. The duration and the intensity of the exercise can gradually be increased according to tolerance. • If symptoms more than mildly increase, or new symptoms appear, stop and briefly rest. Resume at a reduced level of exercise intensity until able to tolerate it without more than mild symptom exacerbation. • Brisk walks and low intensity, body weight resistance training are fine but no high intensity exercise or added weight resistance training.	

Graduated return to activity (education/work) and sport programme

Stage	Focus	Description of activity	Comments
Stage 4	**Return to study and work**	• May need to consider a part-time return to school or reduced activities in the workplace (e.g. half-days, breaks, avoiding hard physical work, avoiding complicated study).	Progressing too quickly through stages 3 - 5 whilst symptoms are significantly worsened by exercise may slow recovery. Although headaches are the most common symptom following concussion and may persist for several months, exercise should be limited to that which does not more than mildly exacerbate them. Symptom exacerbation with physical activity and exercise is generally safe, brief and is self-limiting typically lasting from several minutes to a few hours.
	Non-contact training (e.g. during week 2)	• Start training activities in chosen sport once not experiencing symptoms at rest from the recent concussion. It is important to avoid any training activities involving head impacts or where there may be a risk of head injury. Now increase the intensity of exercise and resistance training.	
Stage 5	**Return to full academic or work-related activity**	• Return to full activity and catch up on any missed work.	Individuals should only return to training activities involving head impacts or where there may be a risk of head injury when they have not experienced symptoms at rest from their recent concussion for 14 days. Recurrence of concussion symptoms following head impact in training should trigger removal of the player from the activity.
	Unrestricted training activities (not before week 3)	• When free of symptoms at rest from the recent concussion for 14 days can consider commencing training activities involving head impacts or where there may be a risk of head injury.	
Stage 6	**Return to competition**	This stage should not be reached before day 21* (at the earliest) and only if no symptoms at rest have been experienced from the recent concussion in the preceding 14 days and now symptom free during pre-competition training. * The day of the concussion is Day 0 (see example below).	Resolution of symptoms is only one factor influencing the time before a safe return to competition with a predictable risk of head injury. Approximately two-thirds of individuals will be able to return to full sport by 28 days but children, adolescents and young adults may take longer. Disabled people will need specific tailored advice which is outside the remit of this guidance.

Example:

- Concussion on Saturday 1st October (Day 0)
- All concussion-related symptoms resolved by Wednesday 5th October (Day 4)
- No less than 14 days is needed before the individual returns to sport-specific training involving head impacts or where there may be a risk of head injury (Stage 5) on Wednesday 19th October (Day 18)
- Continue to be guided by the recommendations above and, if symptoms do not return, the individual may consider returning to competitive sport with risk of head impact on Wednesday 26th October (Day 25)

If symptoms continue beyond 28 days – remain out of sport and medical advice should be sought from a GP (which may in turn require specialist referral and review)

Appendix 2f

IF IN DOUBT, SIT THEM OUT

UK Concussion Guidelines for Non-Elite (Grassroots) Sport

April 2023

UK Government

Supported by

This guidance has been a collaboration between key stakeholders in sport, physical activity and education, athlete healthcare providers, research institutions, the Royal College of General Practitioners, the Royal College of Emergency Medicine, the Society of British Neurological Surgeons and governmental departments from all four UK Home Nations. Special thanks is extended to concussion campaigner Peter Robinson and for the creation of "If In Doubt, Sit Them Out".

Annex 2: First aid trained staff

Arranged in chronological training order *(Training valid for 3 years)*

Staff with training arranged by School Nurse

Name	Date	Training	Training provider	Dept
Emma Pearce	26/02/2026	Emergency Paediatric First Aid Course	Tigerlily	PE
Erik Anders	27/08/2025	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Drama
Christina Balsom	27/08/2025	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Languages
Rachel Barraud	27/08/2025	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Facilities
Shaun Collins-Lindsay	27/08/2025	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Catering
Emma Judge	27/08/2025	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Marketing
Lucy May	27/08/2025	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Science
Eva West	27/08/2025	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	PE
Georgina Bouzyk	02/06/2025	Schools First Aid	Tigerlily	Art
Denise Brennan	02/06/2025	Schools First Aid	Tigerlily	Art
Jo Brereton	02/06/2025	Schools First Aid	Tigerlily	Geography/HoY
Dan Emery	02/06/2025	Schools First Aid	Tigerlily	PE
Susie Haynes	02/06/2025	Schools First Aid	Tigerlily	Science
Carmel Landowski	02/06/2025	Schools First Aid	Tigerlily	Classics
Naomi Lynch	02/06/2025	Schools First Aid	Tigerlily	PE/HoY
Aaron McGuire	02/06/2025	Schools First Aid	Tigerlily	Mathemetics/Asst HoY
Scott Temple	02/06/2025	Schools First Aid	Tigerlily	Science/HoY
Polly O'Donoghue	02/06/2025	Schools First Aid	Tigerlily	Languages
Gillian Young	02/06/2025	Schools First Aid	Tigerlily	School Office
Lucy Fox	12/11/2024	Emergency First Aid at Work (RQF) QNUK L3	Quals Network	PE/Director of Sport
Georgina Brocklehurs	22-23/08/2024	Outdoor First Aid	ITC Fresh Air Training	D of E
Hazel Burrows	22-23/08/2024	Outdoor First Aid	ITC Fresh Air Training	Science/D of E
David Earles	22-23/08/2024	Outdoor First Aid	ITC Fresh Air Training	DT/D of E
Crispin Ingham	22-23/08/2024	Outdoor First Aid	ITC Fresh Air Training	Bursar
Ciaran Bradley	17/06/2024	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Design Technology
Beni Chamberlain	17/06/2024	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	MFL
Nikki Condren	17/06/2024	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	School Nurse
Nelle Dalton	17/06/2024	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Chaplain
Mimi Fogden	17/06/2024	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Food Technology
James Hobbs	17/06/2024	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	RE
Manu Maccherini	17/06/2024	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Classics/HoY
Lucy Miller	17/06/2024	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Business/Economics
Danni O'Laoire	17/06/2024	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Classics
Alan Rees	17/06/2024	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Science
Andrew Smith	17/06/2024	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Maths
Naomi Wilcock	17/06/2024	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	PE
Jennifer Lavelle	19/10/2023	Emergency Paediatric + Emergency First Aid at Work	Hieda	School Nurse
Melanie Mitchell	04/10/2023	Schools First Aid	St John's Ambulance	Support
Amanda Stratton	07/09/2023	Emergency First Aid at Work	Medi Aid UK	Peri Music
Katie Bell	21/06/2023	Emergency Paediatric First Aid	Tigerlily	History
Cindy Bentley	21/06/2023	Emergency Paediatric First Aid	Tigerlily	Housekeeping
Hannah Collier	21/06/2023	Emergency Paediatric First Aid	Tigerlily	History/Asst HoY
Jess Hocking	21/06/2023	Emergency Paediatric First Aid	Tigerlily	Maths
Sarah Oscroft	21/06/2023	Emergency Paediatric First Aid	Tigerlily	Geography
James Quinnell	21/06/2023	Emergency Paediatric First Aid	Tigerlily	English
Ian Taylor-Warwick	21/06/2023	Emergency Paediatric First Aid	Tigerlily	Music
Cathi Woods	21/06/2023	Emergency Paediatric First Aid	Tigerlily	Library
Helen Vizard	21/06/2023	Emergency Paediatric First Aid	Tigerlily	Catering
Alison Rogers	19/06/2023	Schools First Aid	St John's Ambulance	School Office

Support Staff with training arranged by Facilities Manager

Mark Axtmann	27/08/2025	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Transport
Brian Eaton	27/08/2025	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Transport
Paul Francis	27/08/2025	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Caretaking
David Stephenson	27/08/2025	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Caretaking
Lui Federico	22/03/2025	Full Paediatric First Aid	Tigerlily	Transport
Mark Culbert	21/10/2024	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Grounds
Chris Devereux	21/10/2024	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Transport
Nat Donnan	21/10/2024	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Caretaking
Keith Parsons	21/10/2024	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Caretaking
Bobby Varley	21/10/2024	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Grounds
Darren York	21/10/2024	Emergency Paediatric + Emergency First Aid at Work	Tigerlily	Transport

Annex 3: First aid box locations

	First Aid Kit	Location
General Areas:		
	Rennie Surgery – Grab bag	Rennie Surgery
	Staff Room	Staff Room
	Kitchen	Kitchen
	Cupboard opposite Repro	Cupboard opposite Repro
	School Office	School Office
	Emergency Asthma Kit	School Office
	Emergency Anaphylaxis Kit	School Office
	Hall Lobby Defibrillator Box	Hall Lobby
	Library	Library
Grounds:		
	Grounds Workshop	Grounds Workshop
	Tractor Bag Bag 6	Tractor
	Toro buggy Bag 5	Toro Buggy
	Grounds Workshop Bag 8	Grounds Workshop
	Chainsaw Bag 7	Grounds Workshop
	Grounds Team Bag 1	Groundsman
	Grounds Team Bag 2	Groundsman
	Grounds Team Bag 3	Groundsman
	Grounds Team Bag 4	Groundsman
	Grounds Team Bag 5	Groundsman
	Greenpower Hut	Old Tennis Court
	Bee First Aid Kit	Sarah Oscroft (Geography)
PE:		
	Astro	Cupboard next to Astro
	Swimming Pool	Swimming Pool
	PE Defibrillator Box	Sports Hall Lobby
	PE Department – Bag 1	PE Office
	PE Department – Bag 2	PE Office
	PE Department – Bag 3	PE Office
	PE Department – Bag 4	PE Office
	PE Department – Bag 5	PE Office
	PE Department -Bag A PE Department -Bag B	PE Office PE Office
	PE Fixture Kit	PE Office
	Emergency Asthma Kit	PE Office
	Emergency Anaphylaxis Kit	PE Office
Maintenance:		
	Maintenance Workshop	Maintenance Workshop
	Maintenance Van	Maintenance Van
	Minibus GX62 DVG	Minibus
	Minibus RF17 DXT	Minibus
	Minibus CY61 KRK	Minibus
	Minibus RX57 LFJ	Minibus

	Minibus FJ10 LYR	Minibus
Teaching Areas:		
	Biology Prep Room	Biology Prep Room
	Chemistry Prep Room	Chemistry Prep Room
	Physics Prep Room	Physics Prep Room
	Food Technology	Food Technology Room
	Art	Art Room
	Dark Room	Dark Room
	Ceramics	Ceramics Room
	D & T Resistant Materials	D&T Room
	St Joseph's	St Joseph's
	TOTH	TOTH
Trips:		
	Trip First Aid Kit: R	Rennie Surgery
	Trip First Aid Kit: E	Rennie Surgery
	Trip First Aid Kit: N	Rennie Surgery
	Trip First Aid Kit: I	Rennie Surgery
	Trip First Aid Kit: S	Rennie Surgery
	Trip First Aid Kit G	Rennie Surgery
	Trip First Aid Kit Y	Rennie Surgery