Concussion Checklist

Name: _____ Age: _____ Grade: _____ Sport: _____

Date of Injury: _____ Time of Injury: _____

On Site Evaluation

Description of Injury:

_____

_____

_____

_____

Has the athlete ever had a concussion? Yes No

Was there a loss of consciousness? Yes No Unclear

Does he/she remember the injury? Yes No Unclear

Does he/she have confusion after the injury? Yes No Unclear

Symptoms observed at time of injury:

Dizziness: Yes No | Headache: Yes No

Ringing in Ears: Yes No | Nausea/Vomiting: Yes No

Drowsy/Sleepy: Yes No | Fatigue/Low Energy: Yes No

"Doesn't Feel Right:" Yes No | Feeling "Dazed:" Yes No

Seizure: Yes No | Poor Balance/Coord.: Yes No

Memory Problems: Yes No | Loss of Orientation: Yes No

Blurred Vision: Yes No | Sensitivity to Light: Yes No

Vacant Stare/Glassy Eyed: Yes No | Sensitivity to Noise: Yes No

Other Findings/Comments:

_____

_____

Final Action Taken: Parents Notified, Sent to Hospital

Evaluator's Signature: _____ Title:_____ Phone #_____ Parents Signature: _____

Physician Evaluation

Date of First Evaluation:_____ **Time of Evaluation** _____

Date of Second Evaluation: _____ **Time of Evaluation** _____

Symptoms Observed: First Doctor | Visit Second Doctor Visit

Dizziness: Yes No | Yes No

Headache: Yes No | Yes No

Tinnitus: Yes No | Yes No

Nausea: Yes No | Yes No

Fatigue: Yes No | Yes No

Drowsy/Sleepy: Yes No | Yes No

Sensitivity to Light: Yes No | Yes No

Sensitivity to Noise: Yes No | Yes No

Anterograde Amnesia (after impact): Yes No | N/A N/A

Retrograde Amnesia: Yes No | N/A N/A

(backwards in time from impact)

* Please indicate yes or no in your respective columns. First Doctor use column 1 and second Doctor use column 2. First Doctor Visit: Did the athlete sustain a concussion? (Yes or No) (one or the other must be circled) ** Post-dated releases will not be accepted. The athlete must be seen and released on the same day. Please note that if there is a history of previous concussion, then referral for professional management by a specialist or concussion clinic should be strongly considered. Additional Findings/Comments:

_____

_____

Recommendations/Limitations:_____

_____

Signature: _____ Date: _____

Print or stamp name: _____ Phone number: _____

Second Doctor Visit: * Athlete must be completely symptom free in order to begin the return to play progression. If athlete still has symptoms more than seven days after injury, referral to a concussion specialist/clinic should he strongly considered. Please check one of the following:**

[ ] Athlete is asymptomatic and is ready to begin the return to play progression. [ ] Athlete is still symptomatic more than seven days after injury. Signature: _____ Date: _____

Print or stamp name: _____ Phone number: _____

Parent Signature: _____