FORM

2011 7522F
1 of 2

STUDENTS

CONCUSSION PROCEDURES– FORM A
(To be completed by Nurse, Coach, Teacher, Athletic Trainer or Administrator)

Concussion Checklist

Name:_____ Age: _____ Grade:_____

Sport:_____ Date of Injury:_____ Time of Injury:_____

On Site Evaluation
Description of Injury:_____

_____

_____

Has the student 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 the time of injury: (Circle Yes or No)

Dizziness	Yes	No	Headache	Yes	No
Ringing in Ears	Yes	No	Nausea/Vomiting	Yes	No
Drowsy/Sleepy	Yes	No	Fatigue/Low Energy	Yes	No
"Don'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

CONCUSSION MANAGEMENT (FORM A)

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

Other Findings/Comments:_____

_____

_____

Final Action Taken:

Parents Notified Yes No Sent to Hospital Yes No

Evaluator's Signature:_____ Title:_____

Address:_____ Phone No.:_____

Date:_____

Copies: School
Student Accident Report (if applicable)
Parent/Guardian

Implemented: 6/20/11