Onondaga Central School District
Initial Concussion Checklist
Evaluated by Coach or Nurse

Student Name: _____ DOB: _____

Parent Name: _____ Phone: _____

Sport: _____ Date and time of injury: _____

Location of sporting event where injury occurred: _____

Description of injury: _____

_____

_____

Symptoms observed/reported at time of injury:

Amnesia	Yes	No	Nausea	Yes	No
Blurred Vision	Yes	No	Poor Balance/Coord.	Yes	No
Dizzy	Yes	No	Ringing in ears	Yes	No
"Don't feel right"	Yes	No	Seizure	Yes	No
Drowsy/sleepy	Yes	No	Sensitivity to light	Yes	No
Fatigue	Yes	No	Sensitivity to noise	Yes	No
Feeling "dazed"	Yes	No	Sensitivity to sound	Yes	No
Headache	Yes	No	Personality Change	Yes	No
Irritable	Yes	No	Unconscious	Yes	No
Memory Change	Yes	No	Vacant Stare	Yes	No

Please check the box below if it pertains to this injury:

- Student was unconscious for how long: _____
- Does student remember the injury? Yes No
- Were parents at the event? Yes No
- Did parent assume medical responsibility for student? Yes No
- Time parent/guardian notified of incident: _____ By whom? _____

Disposition of Student: To ER/MD _____ Home: _____

Evaluator's Signature: _____ **Title**: _____

Date: _____

****The student is to have this form in their possession if they are transported to the ER or if they go to their primary care MD. After the physician evaluation and reverse side of this form completed, please return the form to the Nurse.****

DO-003 **white – initial evaluator** **yellow – physician (complete reverse side)** **pink - parent**

Onondaga Central School District
Concussion Checklist - Physician

Student Name: _____ DOB: _____

Date of First Evaluation: _____

Second Evaluation: _____

Symptoms observed:

	First Visit		Second Visit	
Amnesia	Yes	No	Yes	No
Drowsy/Sleepy	Yes	No	Yes	No
Fatigue	Yes	No	Yes	No
Headache	Yes	No	Yes	No
Nausea	Yes	No	Yes	No
Noise Sensitivity	Yes	No	Yes	No
Photophobia	Yes	No	Yes	No
Tinnitus	Yes	No	Yes	No
Vertigo	Yes	No	Yes	No

First visit: please circle one response

Did you review the "Initial Concussion Checklist" provided by the Athletic Trainer or Nurse? Yes No

Did the student sustain a concussion? Yes No

Positive finding on neurological exam? Yes No

Comments: _____

Recommendations/Limitations: _____

Physician Signature: _____ **Date**: _____

Second Visit: please check one of the following:

- Student is asymptomatic and is ready to begin the return to play/activity progression.
- Student remains symptomatic after seven days. Refer to a concussion specialist.

Physician Signature: _____ **Date**: _____

****The student is to have this form in their possession if they are transported to the ER or if they go to their primary care MD. It is the responsibility of the student to return the completed form to the Nurse.****