Carbon Copy Document Regulation

STUDENTS 7049.1

CONCUSSION CHECKLIST

Name:______________________Age:___________ Grade:________Sport:___________

Date of Injury:___________ Time of Injury:___________ Location of Event:____________

History

Has the athlete ever had a concussion? ______Yes ______No

(If yes, indicate date, severity, and treatment received)____________________________

Was there a lost of consciousness? ______Yes ______No ______Unclear (If yes, how long?) __________________________________

On Site Evaluation

Description of Injury: ____

Symptoms observed at time of injury:

Symptom			Symptom		
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
Vacant Stare/Glassy Eyed	Yes	No			

***Please circle yes or no for each symptom listed above.**

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

Other Findings/Comments:____

Final Action Taken: Student Released to Parent/Student Sent to Hospital – Parents Notified

Evaluator's Signature:______________________Title:______________________________

Address:_________________________________Date:______ Phone #:______________

Vernon-Verona-Sherrill Central School District
Adopted: 03/08/10, 11/27/17

Parents
Athletic Department
School Nurse

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		
Retrograde Amnesia *(backwards in time from impact)*	Yes	No		

***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 student sustain a concussion? (Yes or No) (one or the other must be circled)

Additional Findings/Comments:____

____

Recommendation/Limitations: ____

____

Physician Signature:____________________________________Date:________________

Physician print or stamp name:___________________________ Phone Number: __________

***Return to school health office**

Second Doctor Visit:

****Student must be completely symptom free without the use of medication for 72 hours (3 days) in order to begin the return to play progression.**

Please check one of the following:

______ Student is asymptomatic without the use of medication and is ready to begin the return to play progression.

______ Student is still symptomatic more than seven days after injury; referral to a concussion specialist/clinic should be strongly considered.

Physician Signature:____________________________________Date: ________________

Physician print or stamp name:___________________________ Phone Number: __________

***Return to school health office**

Regulation

STUDENTS 7049.3

RETURN TO PLAY PROTOCOL

- ✓ The cornerstone of proper concussion management is rest until all symptoms resolved and then a graded program of exertion before return to sport.
- ✓ The program is broken down into six steps in which only one step is covered per day.
- ✓ If any concussion symptoms recur, the student should drop back to the previous level and try to progress after 24 hours of rest.
- ✓ In addition, the student should also be monitored for recurrence of symptoms due to mental exertion, such as reading, working on a computer, or taking a test.

Date	Activity	CMT Leader Initials
_____	**Phase 1** – Low impact, non-strenuous, light aerobic activity such as walking or riding a stationary bike. If tolerated without return of symptoms over a 24 hour period proceed to;	_____
_____	**Phase 2** – Higher impact, higher exertion, and moderate aerobic activity such as running or jumping rope. No resistance training. If tolerated without return of symptoms over a 24 hour period proceed to;	_____
_____	**Phase 3** – Sport specific non-contact activity, low resistance weight training with a spotter. If tolerated without return of symptoms over a 24 hour period proceed to;	_____
_____	**Phase 4** – Sport specific activity, non-contact drills. Higher resistance weight training with a spotter. If tolerated without return of symptoms over a 24 hour period proceed to;	_____
_____	**Phase 5** – Full contact training drills and intense aerobic activity. If tolerated without return of symptoms over a 24 hour period proceed to;	_____
_____	**Phase 6** – Return to full activities without restrictions.	_____

School Medical Director Verbal Clearance:

School Medical Director (Print Name):_______________________________________

- ☐ Athlete has been symptom free for 24 hours
- ☐ Athlete has been evaluated by and received written authorization signed by a licensed physician to participate in his or her particular activity
- ☐ Athlete has successfully completed the Return to Play Progressive Exertion Protocol (Phase 1-5)
- ☐ Athlete is cleared to participate in his or her particular activity (Phase 6)

Obtained by (school staff signature):_________________________ Date:______________

School Medical Director:

Additional Comments:____

Signature:_______________________________________ Date:______________

Print or Stamp Name:_____________________________ Phone Number:___________