

SKANEATELES LAKERS



*Skaneateles Central School District
45 East Elizabeth Street
Skaneateles, New York 13152*

Concussion Checklist

To be filled out at time of injury by coach.

Name: _____ **Age:** _____ **Grade:** _____

Sport: _____ **Level:** _____

Date of Injury: _____

Time of Injury: _____

On Site Evaluation

Description of Injury: _____

The responsibility for observing signs, symptoms, and behaviors that are consistent with a concussion is shared by both sport officials and school officials. The following protocol should be followed if any signs, symptoms or behaviors are observed. The athlete needs to be assessed by an appropriate healthcare professional. School health personnel are considered appropriate health care professionals. School health personnel include the Chief School Medical Officer, school nurse, physician, certified athletic trainer or an EMT that is a member of the on-site EMS squad. If the appropriate health care professional suspects a concussion, the student athlete MAY NOT return to the contest. The athlete MAY NOT return if an appropriate health care professional is not available. The NFHS and NYSPHSAA recommend that any athlete that suffers a concussion should not return to play the day of the injury.

Students who experience one or more of the signs or symptoms of concussions after a bump, blow or jolt to the head, should be referred to a health care professional with experience in Evaluating for a concussion.

*****Please complete the checklist on the back of this form***

Time of Injury: (please circle)

Is confused about events	Yes	No
Repeats questions	Yes	No
Appears dazed or stunned	Yes	No
Answers questions slowly	Yes	No
Can't recall events prior to the hit, bump or fall	Yes	No
Can't recall events after the hit, bump or fall	Yes	No
Loses consciousness (even briefly)	Yes	No
Shows behavior or personality changes	Yes	No
Forgets class schedule or assignments	Yes	No

Physical Symptoms

Headache or "pressure" in head	Yes	No
Nausea or vomiting	Yes	No
Balance problems or dizziness	Yes	No
Fatigue or feeling tired	Yes	No
Blurry or double vision	Yes	No
Sensitivity to light	Yes	No
Sensitivity to noise	Yes	No
Numbness or tingling	Yes	No
Does not "feel right"	Yes	No

Emotional Symptoms

Irritable	Yes	No
Sad	Yes	No
More emotional than usual	Yes	No
Nervous	Yes	No

Cognitive Symptoms

Difficulty thinking clearly	Yes	No
Difficulty concentrating	Yes	No
Difficulty remembering	Yes	No
Feeling more slowed down	Yes	No
Feeling sluggish, hazy, groggy	Yes	No

Please note any changes in status related to the injury over time.

Other Findings/Comments: _____

Final Action Taken: ___ Parents Notified
 ___ Sent to Hospital
 ___ Student referred to Health Care Professional

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

Address: _____

Date: _____ **Phone Number:** _____

****Return to Stacey Patalino ASAP after Contest****