

CONCUSSION CHECKLIST

To be completed by Coaches/Phys. Ed. Teacher and submitted to School Nurse.

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
“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	Sensitivity to Noise	Yes	No
			No		

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

Other Findings/Comments: _____

Final Action Taken:

Parents Notified

Sent to Hospital

Evaluator’s Signature: _____ Title: _____

Address: _____ Date: _____ Phone No.: _____