Onteora Central School District Head Injury Evaluation by Personal Physician

Student Name _____ **Date of Birth** _____

Date of Incident _____

Date of 1st Evaluation _____ **Date of 2nd evaluation (if symptomatic on first visit)** _____

History of previous concussion Y ☐ **N** ☐ **when, and how severe?** _____

_____

What symptoms does the student currently experience?			**Check all that apply or None** ☐		
Symptoms Observed	**First Dr. Visit**			**Second Dr. Visit**	
Neck Pain	Yes	No		Yes	No
Tingling/Numbness in limbs	Yes	No		Yes	No
Seizures	Yes	No		Yes	No
Loss of Consciousness	Yes	No		Yes	No
Loss of orientation	Yes	No		Yes	No
Seeing stars	Yes	No		Yes	No
Vacant stare or glassy eyes	Yes	No		Yes	No
Sensitivity to light	Yes	No		Yes	No
Blurry vision	Yes	No		Yes	No
Tinnitus/ear ringing	Yes	No		Yes	No
Sensitivity to noise	Yes	No		Yes	No
Dizziness or balance problems	Yes	No		Yes	No
Headache	Yes	No		Yes	No
Nausea or vomiting	Yes	No		Yes	No
Fatigue	Yes	No		Yes	No
Difficulty concentrating	Yes	No		Yes	No
Drowsy/sleepy	Yes	No		Yes	No
Difficulty sleeping	Yes	No		Yes	No
Memory problems	Yes	No		Yes	No
Doesn't feel right	Yes	No		Yes	No
Amnesia-Anterograde/retrograde	Yes	No		Yes	No

Were radiology studies obtained? **Yes** ☐ **No** ☐ If yes, please attach results.

Did the student sustain a concussion? **Yes** ☐ **No** ☐ If No may return to full activity.

First Visit: Student is **symptomatic**? **Yes** ☐ (will require follow up visit) **No** ☐ may start "return to activity protocol".

2nd Visit: Student is symptomatic? Yes ☐ (will require follow up visit) **No** ☐ may start return to activity protocol

Comment _____

Signature_____ **Date** _____ **2nd Visit Date** _____

District Medical Director must sign clearance before return to activity protocol begins.

Signature of Medical Director _____ Date _____