CONCUSSION EVALUATION: INITIAL VISIT

TO BE COMPLETED BY PHYSICIAN

PATIENT NAME: _____ DATE OF BIRTH _____

**Post-dated releases will not be accepted. The athlete must be seen and released on the same day. Please note that if there is a history of previous concussion, then referral for professional management by a specialist of concussion clinic should be strongly considered.

Date of First Evaluation: _____ Time of Evaluation: _____

Symptoms Observed:	**First Doctor Visit**		
Dizziness	Yes	No	
Headache	Yes	No	
Tinnitus	Yes	No	
Nausea	Yes	No	
Fatigue	Yes	No	
Drowsy/Sleepy	Yes	No	
Sensitivity to Light	Yes	No	
Sensitivity to Noise	Yes	No	
Anterograde Amnesia	Yes	No	(after impact)
Retrograde Amnesia	Yes	No	(backwards in time from impact)

*Please indicate yes or no in your respective columns. First Doctor use column 1 and second Doctor use Page 2.

Did the student/athlete sustain a concussion? (Yes or No) (One or the other must be circled)

Additional findings/Comments:_____

Recommendations/Limitations: _____

Physician Signature: _____Date:_____

Print or stamp name: _____ Phone number:_____

PLEASE RETURN COMPLETED DOCUMENT TO SCHOOL NURSE

SAVE SHEET 2 FOR SECOND VISIT

CONCUSSION EVALUATION: FOLLOW UP VISIT

TO BE COMPLETED BY PHYSICIAN

PATIENT NAME: _____ DATE OF BIRTH: _____

Date of Second Evaluation: _____ Time of Evaluation: _____

Symptoms Observed:	**Second Doctor Visit**	
Dizziness	Yes	No
Headache	Yes	No
Tinnitus	Yes	No
Nausea	Yes	No
Fatigue	Yes	No
Drowsy/Sleepy	Yes	No
Sensitivity to Light	Yes	No
Sensitivity to Noise	Yes	No

Please check one of the following:

- ○ Athlete is still symptomatic more than 7 days after injury.
- ○ Athlete is asymptomatic and is ready to begin return to play protocol.

Comments, Recommendations/Limitations :

_____

_____

_____

Physician Signature: _____ Date: _____

Print or stamp name: _____ Phone number: _____

PLEASE RETURN COMPLETED DOCUMENT TO SCHOOL NURSE