Collegiate School
Observer Concussion Checklist

Name:_____ Age:_____ Grade:_____ Sport:_____

Date of Injury:_____ Location of Injury _____ Time of Injury_____

On Site Evaluation
Description of Injury: _____

_____

Has the student ever had a concussion?	Yes	No	
Was there a loss of consciousness?	Yes	No	Unclear
Does he remember the injury?	Yes	No	Unclear
Does he 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	No	Sensitivity to Noise	Yes	No
Slowed reaction time	Yes	No	Irritability	Yes	No

Other

Findings/Comments:_____

Final Action Taken: Parent Notified Sent to Hospital

Evaluator's Signature_____ Title_____

Address:_____ Date:_____ Phone No._____

Return form to Athletic Trainer with Accident Report
Form designed by www.impacttest.com