Onteora Central School District Head Injury Initial Incident Evaluation
(to be completed by Coach/Athletic Trainer/Physical Education Teacher/Nurse)

Name of student _____Age_____Grade_____

Date/time/location of incident _____

Name/position of person documenting _____

Sport/activity/How did the Head Injury occur-what happened _____

_____

Is there a previous history of concussion? Yes ☐ No ☐ If yes, how severe and when? _____

_____

Is there a previous history of migraines, seizure disorder, ADHD _____

Evaluator initial observation _____

_____

What symptoms did student experience at the time of the incident or afterwards; check off all that pertain or None ☐

Symptom	Initial	Ongoing?	Symptom	Initial	ongoing?
Knocked out			Blurry vision		
Seizure			Ear ringing		
Neck Pain			Sensitive to noise		
Tingling/numbness in limbs			Dizzy or problems with balance		
Was dazed			Headache		
Loss of orientation			Nausea or vomiting		
Cannot remember incident			Drowsiness		
Vacant stare or glassy eyes			Don't feel right		
Saw stars			Difficulty concentrating		
sensitivity to light			Memory problems		
Other					

Evaluators recommendations if any: _____

_____

Were parents contacted? Yes No Sent to Hospital? Yes No Medical Follow up recommended? Yes No

_____ _____ _____
Evaluator Signature Date Time

October 2018 **Copy to school Nurse/file; copy to Medical Director; copy to personal physician for follow up**

Onteora Central School District Head Injury Evaluation by Personal Physician

Student Name _____ **Date of Birth** _____

Date of Incident _____

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

FIRST VISIT: DATE _____

Presenting Symptoms Or No Symptoms ☐

Neck Pain	Yes	No	Sensitivity to light	Yes	No	Fatigue	Yes	No
Tingling/Numbness in limbs	Yes	No	Blurry vision	Yes	No	Drowsy/sleepy	Yes	No
Seizures	Yes	No	Tinnitus/ear ringing	Yes	No	Difficulty sleeping	Yes	No
Loss of Consciousness	Yes	No	Sensitivity to noise	Yes	No	Memory Problem	Yes	No
Loss of Orientation	Yes	No	Dizziness/balance problem	Yes	No	Not feeling right	Yes	No
Seeing stars	Yes	No	Headache	Yes	No	Amnesia retro/anterograde	Yes	No
Vacant stare or glassy eyes	Yes	No	Nausea/vomiting	Yes	No	Difficulty concentrating	Yes	No

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

Did the student sustain a concussion? **Yes** ☐ **No** ☐

Student is **symptomatic**? **No** ☐ or **Yes** ☐ (will require follow up visit)

***If No concussion diagnosed -** may return to full activity **Yes** ☐ or **No** ☐

Signature_____ Date_____

SECOND VISIT: DATE _____

Presenting Symptoms Or No Symptoms ☐

Neck Pain	Yes	No	Sensitivity to light	Yes	No	Fatigue	Yes	No
Tingling/Numbness in limbs	Yes	No	Blurry vision	Yes	No	Drowsy/sleepy	Yes	No
Seizures	Yes	No	Tinnitus/ear ringing	Yes	No	Difficulty sleeping	Yes	No
Loss of Consciousness	Yes	No	Sensitivity to noise	Yes	No	Memory Problem	Yes	No
Loss of Orientation	Yes	No	Dizziness/balance problem	Yes	No	Not feeling right	Yes	No
Seeing stars	Yes	No	Headache	Yes	No	Amnesia retro/anterograde	Yes	No
Vacant stare or glassy eyes	Yes	No	Nausea/vomiting	Yes	No	Difficulty concentrating	Yes	no

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

Student remains **symptomatic**? **No** ☐ **Yes** ☐ (will require follow up visit)

Must Start "return to activity protocol" **Yes** ☐. **No** ☐

MD Signature_____ Date_____

Phone number_____ Stamp:

Note: Post-dated releases will not be accepted. The student must be seen and released on the same day.
District Medical Director must sign clearance before return to activity protocol begins:

Signature of Medical Director _____ Date_____

2/14/19