Concussion Home Care Instructions

Athlete Name:_____ Date:_____

ATC:_____ Time Of Injury: _____

I believe that your son/daughter has sustained a concussion. It is important for his/her safety and well being that you monitor their condition. If any of the following post concussion symptoms worsen or appear take him/her to the emergency room or contact your family physician:

Headache	Feeling in a fog
Nausea	Irritability
Vomiting	numbness or tingling
Balance Problems/Dizziness	Sensitivity to noise
Sensitivity to Light	ringing of ears
Blurred vision	Difficulty remembering

*Mental status changes: lethargy, difficulty maintaining arousal, confusion

*Decreasing level of consciousness	*Decrease or irregularity of breathing

*these symptoms require immediate transportation to the nearest emergency room

Attached to this sheet is a rating of his/her symptoms following the event for you to use when monitoring the symptoms. Please have them complete the attached symptom checklist prior to going to bed and bring it back when they report to the athletic training room next.

Please remind him/her to report to the athletic training room tomorrow at _____ for a follow up evaluation.

Please do not allow them to:
Take Aspirin or Ibuprofen, drink alcohol, eat spicy foods, or drive a motor vehicle.

Specific instructions:_____
_____

Prior to returning to full activity your son/daughter must be symptom free for 7 days and must be evaluated by a physician and cleared for return to play in writing.

If you have any questions or concerns feel free to contact me at:
Name, Corey Yates ATC
C# (503) 910-9264

Information Provided to: _____

ATC Signature:_____ Date:_____

Guskiewicz K, et al. 2002, Journal of Athletic Training