



Lake Travis ISD  
 Guidelines for High School Sports Concussion and/or Head Injury  
 Management, Neurocognitive Testing & Return to Play Protocol

Athlete Name: \_\_\_\_\_ Date/Time of injury: \_\_\_\_\_ Sport: \_\_\_\_\_  
 Examiner: \_\_\_\_\_ Age: \_\_\_ Gender: **M / F** Current Grade: \_\_\_\_\_ Dominant hand: **Right / Left**  
 How many concussions have you had in the past? \_\_\_\_\_ Most recent concussion: \_\_\_\_\_  
 How long was your recovery from the most recent concussion? \_\_\_\_\_

Have you ever been hospitalized for a head injury? <b>Yes / No</b>	
Have you ever been diagnosed with headaches or migraines? <b>Yes / No</b>	
- Have you ever been prescribed medication for headaches/migraines? <b>Yes / No</b>	
- Do you normally take medication for headaches/migraines? <b>Yes / No</b>	
- Have you taken that medication today? <b>Yes / No</b>	
Have you been diagnosed by ad doctors with a learning disability, dyslexia, ADD / ADHD? <b>Yes / No</b>	
- Have you been prescribed ADD/ADHD medication? <b>Yes / No</b>	
- Do you normally take your ADD/ADHD medication? <b>Yes / No</b>	
- Have you taken that medication today? <b>Yes / No</b>	
Have you been diagnosed with depression, anxiety, or any other psychiatric disorder? <b>Yes / No</b>	
- Have you been prescribed with psychiatric medication? <b>Yes / No</b>	
- Do you normally take medication for a psychiatric disorder? <b>Yes / No</b>	
- Have you taken that medication today? <b>Yes / No</b>	
Have you been to the eye doctor in the last year? <b>Yes / No</b>	
- Have you been prescribed glasses or contacts? <b>Yes / No</b>	
- Which do you wear while participating in sports? <b>Contacts / Glasses / None</b>	
- Which one are you wearing today? <b>Contacts / Glasses / None</b>	
Are you color-blind? <b>Yes / No</b>	
- What color are you color-blind to? <b>Red / Green/ Unsure</b>	
Please list all other medications: _____	
How many hours ago did you last work-out? _____	
- What work-out/activity did you perform? _____	
- What was the intensity? <b>Low Moderate Vigorous</b>	
How many hours did you sleep last night? _____	
- How many hours do you normally sleep? _____	
Are you feeling 100% normal today? <b>Yes / No</b> What percent? _____	
- Why if not, why? _____	

**NOTES:** MOI/ UE&LE Findings/ ROM/ Tenderness

**Delayed Recall** Eat Dog Run **Y / N**  
**Concentration months in reverse order** **Y / N**  
*Dec – Nov – Oct - Sept – Aug – Jul – Jun – May – Apr – Mar – Feb – Jan*

**Balance Examination**  
 Footwear: Shoes / Barefoot / Braces Which foot was tested?

Double Leg Stance	Errors	<b>L / R</b>
Single Leg Stance	Errors	
Tandem Stance	Errors	

**Coordination Examination**  
 Upper limb coordination: Which arm was tested: **L / R Both**  
 Coordination score: \_\_\_ of 1

<b>Digits Backwards</b>			
List A	List B	List C	
4-9-3	5-2-6	1-4-2	Y N 0
6-2-9	4-1-5	6-5-8	Y N 0
3-8-1-4	1-7-9-5	6-8-3-1	Y N 0
3-2-7-9	4-9-6-8	3-4-8-1	Y N 0
6-2-9-7-1	4-8-5-2-7	4-9-1-5-3	Y N 0
1-5-2-8-9	6-1-8-4-3	6-8-2-5-1	Y N 0
7-1-8-4-6-2	8-3-1-9-6-4	3-7-6-5-1-9	Y N 0
5-3-9-1-4-8	7-2-4-8-5-6	9-2-6-5-1-4	Y N 0
Digits Score: ___ /4			

<b>Immediate Memory: 5 Word List</b>	<b>Trial 1</b>	<b>Trial 2</b>	<b>Trial 3</b>
Finger Penny Blanket Lemon Insect			
Candle Paper Sugar Sandwich Wagon			
Baby Monkey Perfume Sunset Iron			
Elbow Apple Carpet Saddle Bubble			
Dollar Honey Mirror Saddle Anchor			
Jacket Arrow Pepper Cotton Movie			
<b>Total:</b>			

<b>Cognitive Assessment</b>		
What month is it?	0	1
What is the date today?	0	1
What is the day of the week?	0	1
What year is it?	0	1
What time is it right now? (w/i hour)	0	1
Orientation score	___ of 5	



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Name: \_\_\_\_\_  
 Sport: \_\_\_\_\_  
 Grade/ Team: \_\_\_\_\_

Date of Injury: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Time: \_\_\_\_\_

**How do you feel?** You should score yourself on the following symptoms, based on how you feel now.

	None	Mild	Moderate	Severe			
1. Headache	0	1	2	3	4	5	6
2. "Pressure in head"	0	1	2	3	4	5	6
3. Neck Pain	0	1	2	3	4	5	6
4. Nausea or vomiting	0	1	2	3	4	5	6
5. Dizziness	0	1	2	3	4	5	6
6. Blurred vision	0	1	2	3	4	5	6
7. Balance problems	0	1	2	3	4	5	6
8. Sensitivity to light	0	1	2	3	4	5	6
9. Sensitivity to noise	0	1	2	3	4	5	6
10. Feeling slowed down	0	1	2	3	4	5	6
11. Feeling like "in a fog"	0	1	2	3	4	5	6
12. "Don't feel right"	0	1	2	3	4	5	6
13. Difficulty concentrating	0	1	2	3	4	5	6
14. Difficulty remembering	0	1	2	3	4	5	6
15. Fatigue or low energy	0	1	2	3	4	5	6
16. Confusion	0	1	2	3	4	5	6
17. Drowsiness	0	1	2	3	4	5	6
18. Trouble falling asleep	0	1	2	3	4	5	6
19. More emotional	0	1	2	3	4	5	6
20. Irritable	0	1	2	3	4	5	6
21. Sadness	0	1	2	3	4	5	6
22. Nervous or Anxious	0	1	2	3	4	5	6

Do symptoms get worse with physical activity? **Yes / No**

Do symptoms get worse with mental activity? **Yes / No**

Total Number of Symptoms: \_\_\_\_\_ Symptom Severity Score: \_\_\_\_\_