

# Regulation

STUDENTS

7101.1

## INITIAL CONCUSSION EVALUATION BY TRAINER OR COACH

Student Athlete Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Student Athlete's Parents Name: \_\_\_\_\_

Student Athlete's Parent's Daytime Phone Number: Home: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Cell: ( ) \_\_\_\_\_ - \_\_\_\_\_

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

Location of sporting event where injury occurred: \_\_\_\_\_

Description of Injury: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **SYMPTOMS OBSERVED OR REPORTED AT TIME OF INJURY**

*\*Please circle yes or no for each symptom listed below.*

Dizziness	Yes	No	Headache	Yes	No
Ringling 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	Retro Grade Amnesia	Yes	No

Other: \_\_\_\_\_  
\_\_\_\_\_

Has student athlete sustained a prior concussion? Yes No  
(If yes, indicate date, severity, and treatment received) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Was there a loss of consciousness? Yes No Unclear  
(If yes, how long?) \_\_\_\_\_

Does student athlete remember the injury? Yes No Unclear

Does student athlete have altered state of consciousness after the injury? Yes No Unclear

Are or were the student athlete's parents at the sporting event at the time of the injury? Yes No

(If yes, did they assume medical responsibilities for their child?) Yes No  
(If no, were the parents notified? By whom?) Yes No \_\_\_\_\_

Additional Findings/Comments: \_\_\_\_\_  
\_\_\_\_\_

Final Action Taken: Student Released to Parents / Student Sent to Hospital – Parents Notified  
*\*\* (Please note the student athlete is to have this initial evaluation in their possession if they are transported to the ER for further evaluation and when they report to their primary MD for each office visit. Parents should assume custody of medical form throughout the entire process) \*\*\**

Evaluator's Name (please print neatly) \_\_\_\_\_

Evaluator's Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_ Date: \_\_\_\_\_ Phone #: \_\_\_\_\_

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Sauquoit Valley Central School District  
Adopted: 5/14/24

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7101.2

## PHYSICIAN CONCUSSION EVALUATION

*(To be completed by Student athlete's primary care Physician or ER Physician ONLY)*

Date of First Evaluation: \_\_\_\_\_ Time of Evaluation: \_\_\_\_\_  
Date of Second Evaluation: \_\_\_\_\_ Time of Evaluation: \_\_\_\_\_

Symptoms Observed:	First Doctor Visit		Second Doctor Visit	
Vertigo	Yes	No	Yes	No
Headache	Yes	No	Yes	No
Tinnitus	Yes	No	Yes	No
Nausea	Yes	No	Yes	No
Fatigue	Yes	No	Yes	No
Drowsy/Sleepy	Yes	No	Yes	No
Photophobia	Yes	No	Yes	No
Sensitivity to Noise	Yes	No	Yes	No
Ante Grade Amnesia	Yes	No		
Retro Grade Amnesia	Yes	No		

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

### **First Doctor Visit:**

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

Additional Findings/Comments: \_\_\_\_\_

Recommendation/Limitations: \_\_\_\_\_

Doctor's Name (print or stamp): \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Second Doctor Visit:**

**\*\*Athlete must be completely symptom free without the use of medication for 72 hours (3 days) in order to begin the return to play progression.**

Please check one of the following:

\_\_\_\_\_ Athlete is asymptomatic without the use of medication and is ready to begin the return to play progression.

\_\_\_\_\_ Athlete is still symptomatic more than seven days after injury and must be referred to a concussion specialist.

Doctor's Name (print or stamp): \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_