Manson School District Head Injury Initial Evaluation

Name:____ Date/Time of Injury:___________________________________

Sport:____ Level (circle): Varsity JV C MS

How did injury occur?____

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Date of previous concussion:______________________ (if any)

	Initial Evaluation		*2nd check at 5 minutes*		*3rd check at 10 minutes*	
Symptoms reported by Athlete	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Headache						
Nausea						
Balance problems or dizziness						
Double or fuzzy vision						
Sensitivity to light or noise						
Feeling sluggish						
Feeling foggy or groggy						
Concentration or memory problems						
Confusion						
Signs observed by Coaching Staff:						
Appears dazed or stunned						
Is confused about assignment						
Forgets plays						
Is unsure of game, score or opponent						
Moves clumsily						
Answers questions slowly						
Loses consciousness						
Shows behavior or personality changes						
Can’t recall events prior to hit						
Can’t recall events after hit						

Action Plan:

- ☐ Athlete removed from play
- ☐ Athlete referred for medical evaluation
- ☐ Athlete’s parent/guardian informed about the known or possible concussion and parent fact sheet given to parent or sent home with athlete.

_________________________________/____________________ ______________________________________

Signature of person completing initial assessment/Date ***Printed Name***