Freedom High School Sports Medicine
1050 Neroly Rd Oakley, CA 94561
Athletic Training Room • (925) 625-5900

Injury Evaluation

DATE _____

NAME _____ AGE _____ SEX: M F

SCHOOL _____ SPORT _____

DATE OF INJURY [DOI]: _____ PHONE # _____

INJURY OCCURRED DURING: Competition Practice Training Other

Evaluation

DISTAL PULSE INTACT : Yes No SENSATION INTACT : Yes No
VISION CONDITION: _____
PUPILS: NA Equal Unequal Dilated R / L Light Reactive R / L
Pinpoint R / L Fixed R / L
SPEECH : NA Normal Slurred Incoherent None
MENTAL STATUS: Conscious Disoriented Unconscious

VITALS : Time _____ _____ _____
B/P _____ _____ _____
Pulse _____ _____ _____
Res Rate _____ _____ _____
SAC _____ _____ _____

HISTORY

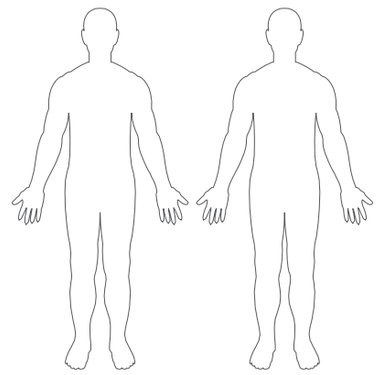
OBSERVATION

PALPATION

ROM

NEUROLOGICAL

STRENGTH



ANTERIOR POSTERIOR

FUNCTION

SPECIAL TEST

ASSESSMENT

PLAN

TREATMENT/ON FIELD 1ST AID

☐ Medical Referral Given for Parent or Physician
☐ Call made to Parent/Guardian. Date _____ Time
☐ MD Evaluation Needed

Evaluated by

Aug 20, 1999 NCR-3

WHITE - Trainers Copy CANARY - Coach/Admin.