

SCSD Concussion/Traumatic Brain Injury Sign & Symptom Checklist

Student Name: _____ Date of Injury: _____ Time of Injury: _____

Directions

- Athletes that sustain a potential head injury must be checked for symptoms of a concussion/TBI at the time of the injury.
- If symptoms are present at this time, athlete must sit for 15 minutes and be rechecked.
- If there are zero symptoms at the 15 minute check, athlete may return to play. If symptoms are present at this time, athlete must be removed from play and medical care sought.

Description of Injury (be specific - where, how, and any additional details): _____

School Employee Completing the Form: _____

Observed Signs & Physical, Cognitive, & Emotional Symptoms

(check all that apply):

@ 0 Minutes (time: _____) @ 15 Minutes (time: _____)

Appears dazed or stunned	_____	_____
Is confused about events	_____	_____
Repeats questions	_____	_____
Answers questions slowly	_____	_____
Can't recall events prior to the hit/bump/fall	_____	_____
Loses consciousness	_____	_____
Shows behavior or personality changes	_____	_____
Headache or "pressure" in the head	_____	_____
Nausea or vomiting	_____	_____
Balance problems or dizziness	_____	_____
Fatigue or feeling tired	_____	_____
Blurry or double vision	_____	_____
Sensitivity to light or noise	_____	_____
Numbness or tingling	_____	_____
Does not "feel right"	_____	_____
Difficulty thinking clearly, concentrating, remembering	_____	_____
Feeling more slowed down	_____	_____
Feeling sluggish, hazy, foggy or groggy	_____	_____
Irritable/sad/nervous/more emotional than usual	_____	_____

Sideline Assessment (Maddock's Score):

Tell the athlete "I'm going to ask you a few questions, please listen carefully and give your best effort."

	Answers Incorrectly	Answers Correctly	
At what venue are we at today?	0	1	
Which half is it now?	0	1	
Who scored the last in this match/game?	0	1	
What team did you play last week/game?	0	1	
Did your team win the last game?	0	1	Total Score: ____/5

Danger Signs To Watch For - If the athlete exhibits any of these symptoms at time of injury or over the next few days, they should be taken to an emergency department for evaluation right away:

- One pupil (black part in the middle of the eye) larger than the other
- Drowsiness or cannot be awakened
- A headache that gets worse and does not go away
- Weakness, numbness, decreased coordination
- Repeated vomiting or nausea
- Convulsions or seizures
- Difficulty recognizing people or places
- Increased confusion, restlessness, or agitation
- Unusual behavior
- Loss of consciousness

For Medical Provider

PIAA Recertification Requirement: If the physician completing this form is clearing the herein named student subsequent to that student sustaining a concussion or traumatic brain injury, that physician must be sufficiently familiar with current concussion management such that the physician can certify that all aspects of evaluation, treatment, and risk of that injury have been thoroughly covered by that physician.

Printed Name of MD/DO: _____

Date & Time of Medical Evaluation: _____

Patient Name: _____

Medical Diagnosis: _____

Patient is (*MUST* circle & initial one of the following, or include specific restrictions/recommendations below):

1. Not Cleared and may not return to participation at this time, additional follow-up medical care required
MD/DO initial _____
2. Cleared to return to participation following the district's five day return to play progression
MD/DO initial _____
3. Concussion/Traumatic brain injury not suspected and athlete is cleared to return to full participation without restrictions or use of any return to play progression
MD/DO initial _____
4. Any additional or other recommendations/restrictions/precautions: _____

MD/DO initial _____

Signature of MD/DO: _____ Date: _____