

CONCUSSION CHECKLIST

Name: _____ Age: _____ Grade _____ Sport: _____

Date of Injury: _____ Time of Injury _____ Location of Event _____

On Site Evaluation:

Description of Injury: _____

Was there loss of consciousness?	Yes	NO	Unclear
Does he/she remember the injury?	Yes	NO	Unclear
Does he/she have confusion after the injury?	Yes	NO	Unclear
Previous history of concussion?	Yes	NO	

(If Yes, indicate date, severity, and treatment received) _____

Symptoms observed at time of injury:

Dizziness	Yes	No	Headache	Yes	No
Ring 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	Los of Orientation	Yes	No
Blurred Vision	Yes	No	Sensitivity to Light	Yes	No
Vacant Stare/ Glassy Eyed	Yes	No	Sensitivity to Noise	Yes	No

Please circle yes or no for each symptom listed above

Other findings or comments: _____

Final Action Taken: Student released to parent / Student sent to Hospital-parents notified

Evaluator’s Signature/Title _____

Date: _____ Time: _____

Physical Evaluation

First Doctor Visit: _____ Date of First Evaluation: _____

* Post-dated releases will not be accepted. Please note that if there is a history of previous concussion, then referral for professional management by a specialist or concussion clinic should be strongly considered.

Symptoms Observed:

Dizziness	Yes	No	Drowsy/Sleepy	Yes	No
Headache	Yes	No	Sensitivity to light	Yes	No
Tinnitus	Yes	No	Sensitivity to noise	Yes	No
Nausea	Yes	No	Anterograde Amnesia	Yes	No
Fatigue	Yes	No	Retrograde to Amnesia	Yes	No

*Please indicate yes or no in your respective columns. *

Did the athlete sustain a concussion? (Yes or No) (one or more must be circled)

Additional Findings/Comments: _____

Signature: _____ Date: _____

Print/Stamp Name: _____ Phone # _____

Second Doctor Visit: _____ Date of First Evaluation: _____

* Post-dated releases will not be accepted. Please note that if there is a history of previous concussion, then referral for professional management by a specialist or concussion clinic should be strongly considered.

Symptoms Observed:

Dizziness	Yes	No	Drowsy/Sleepy	Yes	No
Headache	Yes	No	Sensitivity to light	Yes	No
Tinnitus	Yes	No	Sensitivity to noise	Yes	No
Nausea	Yes	No	Anterograde Amnesia	Yes	No
Fatigue	Yes	No	Retrograde to Amnesia	Yes	No

*Please indicate yes or no in your respective columns. *

Did the athlete sustain a concussion? (Yes or No) (one or more must be circled)

Additional Findings/Comments: _____

Signature: _____ Date: _____

Print/Stamp Name: _____ Phone # _____

ZURICH PROGRESSIVE EXERTION PROTOCOL

- The cornerstone of proper concussion management is rest until all symptoms resolve and then a graded program of exertion before return to sport.
- The program is broken down into six steps in which only one step is covered per day.
- If any concussion symptoms recur, the athlete should drop back to the previous level and try to progress after 24 hours of rest.
- In addition, the student should also be monitored for recurrence of symptoms due to mental exertion, such as reading, working on a computer, or taking a test.

Date	Activity	CMT/Initials
_____	Phase 1- Low impact, non-strenuous, light aerobic activity such as walking or riding a stationary bike. If tolerated without return of symptoms over a 24hr period to proceed to;	_____
_____	Phase 2- Higher impact, higher exertion, and moderate aerobic activity such as running or jumping rope. No resistance training. If tolerated without return of symptoms over a 24hr period to proceed to;	_____
_____	Phase 3- Sport specific, non-contact activity, low resistance weight training with a spotter. If tolerated without return of symptoms over a 24hr period to proceed to;	_____
_____	Phase 4- Sport specific activity, non-contact drills. Higher resistance weight training with a spotter. If tolerated without return of symptoms over a 24hr period proceed to;	_____
_____	Phase 5- Full contact training drills and intense aerobic activity. If tolerated without return of symptoms over a 24hr period proceed to;	_____
_____	Phase 6- Return to full activities without restrictions.	_____

School Medical Director Release:

Athlete has been symptom free for 24hrs

Athlete has been evaluated by and received written authorization signed by a licensed physician to participate in his/her particular activity.

Athlete has successfully completed Zurich Progressive Exertion Protocol

Athlete is cleared to participate in his/her particular activity

Additional Comments: _____

Signature: _____ Date _____

Print Name: _____ Phone # _____

CONCUSSION MANAGEMENT PROTOCOL EXPLANATION

The following protocol has been established in accordance to the Concussion Management and Awareness Act (Chapter 496 of the laws of New York, 2011) and the International Conference on Concussion in Sport, Zurich 2008. In addition, it has been fabricated in a collaborative effort with your District's medical and administrative staff, concussive experts in the Central New York area, the Multi-BOCES Labor Relations & Policy Office, the NYSPHSAA, and Slocum Dickson Sports Medicine.

- A student who has sustained, or is believed to have sustained, a mild traumatic brain injury (also known as concussion) must be immediately removed from participation in athletic activities. Athletic activities, for this purpose, include competition, practices, conditioning, and any other school-sponsored athletic program. In the event there is any doubt as to whether a student has sustained a mild traumatic brain injury, it shall be presumed that the student has been so injured until proven otherwise.

- A student removed from participation in athletic activity may resume participation in athletic activity when the student completes the following steps (in order):
 - A. Be evaluated by a licensed physician within the 24 hours following the injury (Doctor Visit One). The Student must have the initial Physician Evaluation filled out completely, signed and dated when reporting to the School Concussion Management Team (CMT) Leader.

 - B. Be symptom free for 24 hours, without the use of medication.

 - C. Follow-up and be evaluated by a licensed physician when asymptomatic (Doctor Visit Two) to be cleared to begin the Zurich Progressive Exertion Protocol (ZPEP). The Student must have the second Physician Evaluation filled out completely, signed and dated when reporting to the School CMT Leader.

- Following successful completion of the ZPEP, the school CMT Leader must obtain clearance from the District's medical director prior to the student's "return to full activities without restrictions."