

# Waterville Central School District

## SUPERINTENDENT'S REGULATION

STUDENTS

7103.3

### PHYSICIAN EVALUATION

Date of First Evaluation: \_\_\_\_\_

Time of Evaluation: \_\_\_\_\_

Date of Second Evaluation: \_\_\_\_\_

Time of Evaluation: \_\_\_\_\_

Symptoms Observed:	First Doctor Visit		Second Doctor Visit	
	Yes	No	Yes	No
Dizziness	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
Sensitivity to Light	Yes	No	Yes	No
Sensitivity to Noise	Yes	No	Yes	No
Anterograde Amnesia (alter impact)	Yes	No	Yes	No
Retrograde Amnesia (backwards in time from impact)	Yes	No	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 student sustain a concussion? (Yes or No) (one or the other must be circled)

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

Recommendations/Limitations: \_\_\_\_\_

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

#### Second Doctor Visit:

\*\*\* Student must be symptom free for 24 hours in order to begin the return to play progression.

Please check one of the following:

- Student is asymptomatic and is ready to begin the return to play progression.
- Student is still symptomatic more than seven days after injury and must be referred to a concussion specialist.

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

Print or stamp name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Approved by the Superintendent: 09/11/12, 01/23/18