

Waterville Central School District

SUPERINTENDENT'S REGULATION

STUDENTS

7103.2

CONCUSSION CHECKLIST

Name: _____ Age: _____ Grade: __ Sport: _____

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

History

Has the student ever had a concussion? Yes No
(If yes, indicate date, severity, and treatment received) _____

Was there a loss of consciousness? Yes No Unclear
(If yes, how long?) _____

On Site Evaluation

Description of Injury: _____

Symptoms observed at time of injury:

Dizziness	Yes	No	Headache	Yes	No
ringing 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	Loss 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.

Does he/she remember the injury? Yes No Unclear
Does he/she have confusion after the injury? Yes No Unclear

Other Findings/Comments: _____

Final Action Taken: Student Released to Parents / Student Sent to Hospital – Parents Notified

Evaluator’s Signature: _____ Title: _____

Address: _____ Date: _____ Phone No.: _____

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