GREAT NECK PUBLIC SCHOOLS
Athletics Dept.

CONCUSSION CHECKLIST

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

Date of Injury: _____Time of Injury:_____Site of Injury:_____

On Site Evaluation
Description of Injury:_____
_____
_____

Has the athlete ever had a concussion? Yes No

Was there a 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

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.

Other Findings/Comments:_____
_____

Final Action Taken: Parents Notified Sent to Hospital

Evaluator's Signature:_____Title:_____

School Assignment or Mailing Address:_____

Date:_____Phone No.:_____

Top copy for building nurse's records----Bottom copy for parents of athlete

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Physician Evaluation

Name:_____ **Age:**_____ **Grade:**_____ **Sport:**_____

Date of Injury:_____ **Time of Injury:**_____ **Site of Injury:**_____

Date of First Evaluation:_____ **Time of Evaluation:**_____

Date of Second Evaluation:_____ **Time of Evaluation:**_____

Symptoms Observed:	**First Doctor Visit**		**Second Doctor Visit**	
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 *(after impact)*	Yes	No	N/A	N/A
Retrograde Amnesia *(backwards in time from impact)*	Yes	No	N/A	N/A

* 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 athlete sustain a concussion? (**Yes** or **No**) (one or the other must be circled)

**** Post-dated releases will not be accepted. The athlete must be seen and released on the same day.**
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.

Additional Findings/Comments:_____

_____

Recommendations/Limitations:_____

_____

Signature:_____ Date:_____

Physician's stamp:_____ Phone number:_____

Second Doctor Visit:

***** Athlete must be completely symptom free in order to begin the return to play progression. If athlete still has symptoms more than seven days after injury, referral to a concussion specialist/clinic should he strongly considered.**

Please check one of the following:

- ☐ Athlete is asymptomatic and is ready to begin the return to play progression.
- ☐ Athlete is still symptomatic more than seven days after injury.

Signature:_____ Date:_____

Physician's stamp:_____ Phone number:_____

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Athletics Dept.

Return to play Protocol following a concussion.

The following protocol has been established in accordance to the National Federation of State High School Associations and the International Conference on Concussion in Sport, Prague 2004.

When an athlete shows **ANY** signs or symptoms of a concussion:

1. The athlete will not be allowed to return to play in the current game or practice.
2. The athlete should not be left alone, and regular monitoring for deterioration is essential over the initial few hours following injury.
3. The athlete should be medically evaluated following the injury.
4. Return to play must follow a medically supervised stepwise process.

Proper concussion management requires rest until all symptoms resolve and then a graded program of exertion before return to full participation. The program is broken down into five steps in which only one step is covered a day. The five steps involve the following:

STEP	**STAFF EVALUATING (Signature and date)**
Precondition: No exertional activity until asymptomatic for 24 hours.	Personal and District Physician as per Physician's Evaluation Form
1. Light aerobic exercise such as walking or stationary bike, etc. No resistance training.	
2. Sport specific exercise such as skating, running, etc. Progressive resistance training may begin.	
3. Non-contact training/skill drills.	
4. Full contact training in practice setting.	
5. Return to competition	

If any concussion symptoms recur, the athlete must drop back to the previous level and attempt again after 24 hours of rest.

The student-athlete should also be monitored for recurrence of symptoms due to mental exertion, such as reading, working on a computer, or taking a test.

The Return to Play Protocol must involve 2 or more district staff members from among the following: coach of the team, coach of another team, member of the Physical Education staff, building PE Chair/AD, athletic trainer, and building nurse.