SKANEATELES LAKERS

Skaneateles Central School District
49 East Elizabeth Street
Skaneateles, New York 13152

Concussion Checklist

To be filled out at time of injury by coach.

Name: _____ Age: _____ Grade: _____

Sport: _____ Level: _____

Date of Injury: _____

Time of Injury: _____

On Site Evaluation

Description of Injury: _____

_____

The responsibility for observing signs, symptoms, and behaviors that are consistent with a concussion is shared by both sport officials and school officials. The following protocol should be followed if any signs, symptoms or behaviors are observed. The athlete needs to be assessed by an appropriate healthcare professional. School health personnel are considered appropriate health care professionals. School health personnel include the Chief School Medical Officer, school nurse, physician, certified athletic trainer or an EMT that is a member of the on-site EMS squad. If the appropriate health care professional suspects a concussion, the student athlete MAY NOT return to the contest .The athlete MAY NOT return if an appropriate health care professional is not available. The NFHS and NYSPHSAA recommend that any athlete that suffers a concussion should not return to play the day of the injury. A student athlete that has been diagnosed with a concussion MUST be cleared by the Chief School Medical Officer.

Students who experience one or more of the signs or symptoms of concussions after a bump, blow or jolt to the head, should be referred to a health care professional with experience in Evaluating for a concussion.

*****Please complete the checklist on the back of this form***

Concussion Administrative Procedures & Guidelines-Concussion Checklist

Signs and Symptoms Observed at

Time of Injury: (please circle)

Is confused about events	**Yes**	**No**
Repeats questions	**Yes**	**No**
Appears dazed or stunned	**Yes**	**No**
Answers questions slowly	**Yes**	**No**
Can't recall events prior to the hit, bump or fall	**Yes**	**No**
Can't recall events after the hit, bump or fall	**Yes**	**No**
Loses consciousness (even briefly)	**Yes**	**No**
Shows behavior or personality changes	**Yes**	**No**
Forgets class schedule or assignments	**Yes**	**No**

Physical Symptoms

Headache or "pressure" in head	**Yes**	**No**
Nausea or vomiting	**Yes**	**No**
Balance problems or dizziness	**Yes**	**No**
Fatigue or feeling tired	**Yes**	**No**
Blurry or double vision	**Yes**	**No**
Sensitivity to light	**Yes**	**No**
Sensitivity to noise	**Yes**	**No**
Numbness or tingling	**Yes**	**No**
Does not "feel right"	**Yes**	**No**

Emotional Symptoms

Irritable	**Yes**	**No**
Sad	**Yes**	**No**
More emotional than usual	**Yes**	**No**
Nervous	**Yes**	**No**

Cognitive Symptoms

Difficulty thinking clearly	**Yes**	**No**
Difficulty concentrating	**Yes**	**No**
Difficulty remembering	**Yes**	**No**
Feeling more slowed down	**Yes**	**No**
Feeling sluggish. hazy, groggy	**Yes**	**No**

Please note any changes in status related to the injury over time.

Other Findings/Comments: _____

Final Action Taken: __ Parents Notified
__ Sent to Hospital
__ Student referred to Health Care Professional

Evaluator's Signature:_____Title:_____

Address: _____

Date: _____ Phone Number: _____

****Return to Stacey Patalino ASAP after Contest****