OUR LADY OF LOURDES HIGH SCHOOL
CONCUSSION CHECKLIST & PHYSCIAN EVALUATION FORM

Name: ___________________________ Age: _____ Grade: ____ Sport: _________________

Date of Injury: __________________________ Time of Injury: ________________________

On Site Evaluation
Description of Injury:
____
____
____

Has the athlete ever had a concussion?	Yes	No	If yes, how many? _______________
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/ Sensitivity to Noise	Yes	No			

Other findings/Comments:
____
____

Final Action Taken: ☐Parents Notified ☐Referred to Primary Care Physician ☐Sent to Hospital
Evaluator's Signature: ___________________________ Title: ___________________________
Date: ________________________ Phone: ___________________Fax:_____________________

The reverse side of this form is for the Physician's use. This form MUST be returned to the Athletic Training staff before student athletes are allowed to begin the Return to Play Progression.
Thank you for your cooperation.

PHYSICIAN EVALUATION

NOTE:*Unless the student athlete was sent immediately to the hospital after injury for a primary evaluation, **both** doctor visits must be made by the student athlete's **primary care physician**. The follow up visits may be conducted by a specialist if the student is referred to one for management.*

Date of 1st Evaluation: ________________________ **Time of Evaluation: ____________**
Date of 2nd 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	Yes	No	N/A	N/A
Retrograde Amnesia	Yes	No	N/A	N/A

First Doctor Visit:
Did the athlete sustain a concussion? Yes No (One or the other MUST be circled)
AdditionalFindings/Comments:____
____
Recommendations/Limitations:____
____
Signature: ______________________________________ Date: _______________________
Print or stamp name: ______________________________ Phone number: ______________

Second Doctor Visit:
**Post-dated releases will *not* be accepted. The athlete must be seen and released on the *same* day. Athlete must be completely symptom free in order to begin the return to play progression. If the athlete still has symptoms more than seven days after injury, referral to a concussion specialist should be strongly considered.
Please check one of the following:
- ☐ **Athlete is asymptomatic and ready to begin the return to play progression.**
- ☐ **Athlete is still symptomatic and cannot begin the return to play progression.**

Signature: ______________________________________ Date: _______________________
Print or stamp name: ______________________________ Phone number: ______________

Additional Doctor Visit
*for use only if student athlete was not cleared after second doctor visit.
Please check one of the following:
- ☐ **Athlete is asymptomatic and ready to begin the return to play progression.**
- ☐ **Athlete is still symptomatic and cannot begin the return to play progression.**

Signature: _____________________________________ Date: _________________________
Print or stamp name: ______________________________ Phone number: ______________
A written doctor's note will be needed for clearance after a 3rd visit where a student athlete is still symptomatic.