Concussion Signs & Symptoms Checklist

Student Name:_____ Date/Time of Injury:_____

Description of Injury (where injury occurred, how it occurred and description of injury):

_____

_____

_____

_____

School Employee Completing Form:_____

Observed Signs: (check all that apply)	**0 Minutes**	**15 Minutes**
Appears dazed or stunned	_____	
Is confused about events	_____	
Repeats questions	_____	
Answers questions slowly	_____	
Can't recall events prior to the hit, bump or fall	_____	
Can't recall events after the hit, bump or fall	_____	
Loses consciousness	_____	
Shows behavior or personality changes	_____	
Headache or "pressure" in head	_____	
Nausea or vomiting	_____	
Balance problems or dizziness		_____
Fatigue or feeling tired	_____	
Blurry or double vision	_____	
Sensitivity to light or noise	_____	
Numbness or tingling	_____	
Does not "feel right"	_____	
Difficulty thinking clearly	_____	
Difficulty concentrating	_____	
Difficulty remembering	_____	
Feeling more slowed down	_____	
Feeling sluggish, hazy, foggy or groggy	_____	
Irritable	_____	
Sad	_____	
More emotional than usual	_____	
Nervous	_____	

Sideline Assessment - Maddock's Score

"I am going to ask you a few questions, please listen carefully and give your best effort."

At what venue are we at today?	0	1
Which half is it now?	0	1
Who scored last in this match/game?	0	1
What team did you play last week/game?	0	1
Did your team win the last game?	0	1

Maddocks score ___/5

Danger Signs for Parents/Guardians to Watch For: If your child exhibits any of these symptoms, child should be taken to an emergency department right away:

-One pupil (black part in the middle of the eye) larger than the other
-Drowsiness or cannot be awakened
-A headache that gets worse and does not go away
-Weakness, numbness, or decreased coordination
-Repeated vomiting or nausea
-Convulsions or seizures
-Difficulty recognizing people or places
-Increasing confusion, restlessness or agitation
-Unusual behavior
-Loss of consciousness (even brief should be taken seriously)

For Medical Provider:

Name of M.D./D.O.: _____

Date & Time of Medical Review:_____

Patient Name:_____

Medical Diagnosis:_____

Patient is (circle one): Cleared for Immediate Return to Play / Not Cleared for Return to Play

Medical Restrictions:_____

_____

_____

_____

Signature of M.D./D.O.:_____