Appendix B

WALLKILL CENTRAL SCHOOL DISTRICT
CONCUSSION CHECKLIST
(Must be completed by Coach or Medical Staff)

Name: _____ Age: ____ Grade: _____ Sport/Activity: _____

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

On Site Evaluation

Description of Injury: _____

_____

_____

Has the athlete/student 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*:
* Please circle yes or no for each symptom listed below.

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

Other Findings/Comments: _____

_____

Final Action Taken: Parents Notified Sent to: Hospital Home

Evaluator's Signature: _____ Title: _____

Address: _____ Date: _____ Phone No: _____

If an injury is diagnosed as a concussion, the athlete/student will require medical clearance that he/she is symptom free for at least 24 hours in order to begin the return-to-play protocol. The primary care physician must complete the Concussion Medical Clearance Form (Appendix C).

PARENT OR ATHLETE/STUDENT PLEASE RETURN THE CONCUSSION MEDICAL CLEARANCE FORM (APPENDIX C) TO HEALTH OFFICE BEFORE RETURNING TO ACTIVITY

White Copy - To Parent
Yellow Copy - Submit to Health Office