Appendix C

Wallkill Central School District
Concussion Management Medical Clearance

Name: _____ **Date of Injury:** _____ **School:** _____

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/student sustain a concussion? (Yes or No) (one or the other must be circled)

****Post-dated releases will not be accepted. The athlete/student 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: _____

Print or stamp name: _____ Phone number: _____

Second Doctor Visit:

****Athlete/student 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 be strongly considered.**

Please check one of the following:

☐ Athlete/student is asymptomatic and is ready to begin the return to play progression.

☐ Athlete/student is still symptomatic more than seven days after injury.

Signature: _____ Date: _____

Print or stamp name: _____ Phone number: _____