School Physician Evaluation

A _____student has an appointment at your office for evaluation/follow-up for a possible concussion. The _____School District has adopted a specific concussion management and return to participation policy based on the Consensus Statement on Concussion in Sport resulting from the 3rd International Conference on Concussion in Sport, Zurich 2008. A copy of this consensus statement is available for your review upon request.

A copy of the original accident report and all related evaluation forms has been sent to your office to provide an overview of the acute injury. To help us provide our students with the most prudent care possible, please complete the following form after completing your evaluation and return it, and any additional instructions, to the athlete.

Thank You.

Athlete's Name: _____ Date of Evaluation: _____

Signs and Symptoms Observed	**None**		**Moderate**			**Severe**	
Headache	0	1	2	3	4	5	6
Pressure in Head	0	1	2	3	4	5	6
Neck Pain	0	1	2	3	4	5	6
Balance problems/dizziness	0	1	2	3	4	5	6
Nausea or vomiting	0	1	2	3	4	5	6
Vision problems	0	1	2	3	4	5	6
Hearing problems/tinnitus	0	1	2	3	4	5	6
Don't feel right	0	1	2	3	4	5	6
Feeling "dinged" or "dazed"	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Fatigue or low energy	0	1	2	3	4	5	6
More emotional than usual	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6
Sadness / depression	0	1	2	3	4	5	6
Nervousness/anxious	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
Sleeping more than usual	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Other _____	0	1	2	3	4	5	6

Retrograde amnesia	Yes	No
Anterograde amnesia	Yes	No

Did this athlete sustain a concussion: Yes No (One or the other must be circled)
**Post-dated releases will not be accepted. The athlete must be seen and released on the same day.

Please check one of the Following:

_____ Athlete is asymptomatic and able to begin step-wise return to play protocol indicated on the back of this form.

_____Athlete is symptomatic and requires a follow-up evaluation. Date of follow-up: _____

_____Athlete is symptomatic after 7 days and should be referred to a neuropsychologist.

_____ Other: _____

Signature: _____ Date: _____

_____ Central School District
Step-Wise Concussion Return-to-Participation Protocol

No activity, complete rest. Once asymptomatic, proceed to levels using the following progression:

1. Light aerobic exercise such as walking or stationary cycling, no resistance training.
2. Sports specific exercise (skating in hockey, running in soccer, etc.) progressive addition of resistance training at steps 3 or 4.
3. Non-contact training drills.
4. Full contact training/or exertional testing after final medical clearance.
5. Game play.

With this step-wise progression, the athlete should continue to proceed to the next level if asymptomatic during the 24 hours after completion of the current level. If any post concussion symptoms occur, the patient should rest until asymptomatic and begin the progression again following resolution of all signs and symptoms.