CONCUSSION CHECKLIST
New York State Public High School Athletic Association

The NYSPHSAA has endorsed this Concussion Checklist as a valuable tool and recommends use of this checklist, or a similar checklist, by all NYSPHSAA school districts.

Name: _____ Age:_____ Grade: _____ Sport:_____

Date of Injury:_____Time of Injury:_____

On Site Evaluation
Description of Injury:_____
_____
_____

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/ Glassy Eyed	Yes	No			

* Please circle yes or no for each symptom listed above.

Other Findings/Comments:_____
_____
_____

Final Action Taken: Parents Notified _____ Sent to Hospital _____

Evaluator's Signature:_____Title:_____

Address:_____Date:_____Phone No.:_____

Physician Evaluation

Date of Evaluation:_____ **Time of Evaluation:**_____

Symptoms Observed:	**Initial Evaluation**		**Final Evaluation**	
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
Ante Grade Amnesia	Yes	No	Yes	No
Retro Grade Amnesia	Yes	No	Yes	No

Please indicate yes or no in your respective columns.
Initial evaluation use column 1 and final evaluation use column 2.

Additional Findings/Comments:_____

Recommendations/Limitations:_____

Signature:_____ Date:_____

Final Determination and Return to Play Physician:
Is the athlete ready to return to activity? (**Yes** or **No**)
Additional Findings/Comments:_____

Signature: _____ Date: _____

School Physician Signature: _____ Date: _____