POST HEAD INJURY CHECKLIST

NAME: _____ Age: _____ Grade: _____

DATE of injury: _____ TIME of injury: _____ SPORT: _____

Description of Injury: _____

_____

_____

Please *circle* Yes or No for each symptom listed below -

Has the athlete 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:

Dizziness	Yes	No	Ringing in Ears	Yes	No
Drowsy/Sleepy	Yes	No	"Don't Feel Right"	Yes	No
Seizure	Yes	No	Memory Problems	Yes	No
Blurred Vision	Yes	No	Vacant/Glassy Stare	Yes	No
Headache	Yes	No	Nausea/Vomiting	Yes	No
Fatigue/Low Energy	Yes	No	Feeling "Dazed	Yes	No
Poor Balance/Coordination	Yes	No	Loss of Orientation	Yes	No
Sensitivity to Light	Yes	No	Sensitivity to Noise	Yes	No

Other Findings / Comments: _____

_____

Final Action Taken

Parents Notified? Yes No Sent to Hospital? Yes No

Date: _____

Evaluator's Signature: _____ Title: _____

Address: _____ Tel# _____

Please note: If this student had ImPACT performed at school, the baseline scores are available from the health office upon a physician's request. The physician may also request a post-injury test.