

# Concussion Management Form for the Medical Professional

This form is to be completed by a licensed health care provider. Providers are encouraged to review the CDC website if they have questions regarding the latest information on the evaluation and care of the youth athlete following a concussion injury.

YOUTH ATHLETE'S NAME		DATE	SPORT
DATE OF BIRTH	AGE	SCHOOL/TEAM	
REPORTER <input type="checkbox"/> PATIENT <input type="checkbox"/> PARENT <input type="checkbox"/> CAREGIVER(S) <input type="checkbox"/> SIBLING(S) <input type="checkbox"/> FIRST RESPONDER <input type="checkbox"/> COACH <input type="checkbox"/> OTHER:			

## INJURY CHARACTERISTICS

Date/Time of Injury:

Injury Description:

Location of Impact:  Lt Frontal  Rt Frontal  Lt Parietal  Rt Parietal  Occipital  Crown  Neck  Indirect Force

Are there any events just BEFORE the injury that you have no memory of?  YES  NO

Are there events just AFTER the injury that you have no memory of?  YES  NO

Loss of Consciousness:  YES  NO If yes, for how long? Seizures:  YES  NO

Initial Signs:  dazed or stunned  confused about events  answered questions slowly  repeated questions  forgetful

## SYMPTOM CHECKLIST - Since the injury has the person experienced any of these symptoms?

PHYSICAL		COGNITIVE		SLEEP	
Headache	Yes   No	Confusion	Yes   No	Drowsiness	Yes   No
Nausea	Yes   No	Feeling slowed down	Yes   No	Sleeping less than usual	Yes   No
Vomiting	Yes   No	Difficulty concentrating	Yes   No	Sleeping more than usual	Yes   No
Balance problems	Yes   No	Difficulty remembering	Yes   No	Trouble falling asleep	Yes   No
Dizziness	Yes   No	EMOTIONAL		Exertion: Do symptoms worsen with:	
Visual problems	Yes   No	Irritability	Yes   No	Physical Activity? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Fatigue	Yes   No	Sadness	Yes   No		
Sensitivity to light	Yes   No	More emotional	Yes   No	Cognitive Activity? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Sensitivity to noise	Yes   No	Nervousness	Yes   No		
Numbness	Yes   No				

## Refer to the emergency department with sudden onset of any of the following:

- |                          |                                       |  |                                    |
|--------------------------|---------------------------------------|--|------------------------------------|
| * Headaches that worsen  | * Looks very drowsy/can't be awakened | * Can't recognize people or places     | * Neck pain                        |
| * Seizures               | * Repeated vomiting                   | * Increasing confusion or irritability | * Unusual behavioral change        |
| * Focal neurologic signs | * Slurred speech                      | * Weakness or numbness in arms/legs    | * Change in state of consciousness |

## RETURN TO SPORTS

- Athletes are not allowed return to practice or play the same day that their head injury occurred.
- Athletes should never return to play or practice if they still have ANY symptoms.
- More than one evaluation is typically necessary for medical clearance for concussion as symptoms may not fully present for days.
- Due to the need to monitor concussions for recurrence of signs & symptoms with cognitive or physical stress, Emergency Room and Urgent Care physicians typically do not make clearance decisions at the time of the first visit.

## MEDICAL PROVIDER RETURN TO SCHOOL/PLAY RECOMMENDATIONS - This return to school/play is based on today's evaluation.

- |   |   |
|---|---|
| <input type="checkbox"/> Do not return to school  | <input type="checkbox"/> Return to School on _____  |
| <input type="checkbox"/> No Academic Modifications Needed   | <input type="checkbox"/> Academic Modifications Needed (Complete Return to School Form)       |
| <input type="checkbox"/> No activity or sports restrictions are necessary.  | <input type="checkbox"/> No sports practice, physical education, or competition at this time. |
| <input type="checkbox"/> May start return to play progression under the supervision of the health care provider. (Complete Return to Play Form) |   |
| <input type="checkbox"/> Must return to medical provider for final clearance to return to competition   |   |

LICENSED HEALTH CARE PROVIDER NAME	SPECIALTY (CIRCLE ONE) MD DO Neuropsychologist PA APN Other:
OFFICE ADDRESS	SIGNATURE
PHONE NUMBER	DATE