Poughkeepsie City School District
Concussion Evaluation Checklist

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

Date of Injury: _____/_____/_____ Time of Injury: _____:_____

On Site Evaluation

Mechanism of Injury: _____
_____
_____

Does the athlete have a previous history of concussions? YES NO Unknown

Was there **loss of consciousness?** YES NO Unknown

Did the athlete have a **seizure?** YES NO Unknown

Does the athlete recall the injury? YES NO Unknown

Does the athlete have confusion post injury? YES NO Unknown

Signs and Symptoms Observed at the Time of Injury

Dizziness	YES	NO	Headache	YES	NO	Drowsy/Sleepy	YES	NO
Fatigued	YES	NO	Feeling "Dazed"	YES	NO	Poor Balance	YES	NO
Blurry Vision	YES	NO	Sensitivity to light	YES	NO	Sensitivity to noise	YES	NO
Memory problems	YES	NO	Ringing in Ears	YES	NO	Loss of Orientation	YES	NO
Vacant stare	YES	NO	Glassy Eyes	YES	NO	Nausea	YES	NO

Other signs and symptoms: _____
_____
_____

Plan of Care

Immediate Referral? YES NO If so, where: _____

Parents Notified: _____ ImPACT Baseline Test Available: YES NO

Primary Care Physician of Athlete: _____

Signature of Evaluator: _____ Date: ____/____/____