Poughkeepsie City School District
Physician Concussion Evaluation

Name of Athlete: _____ Age: _____ Sport: _____

Date of 1st Evaluation: ____/____/____ Time of 1st Evaluation: ____:____

Date of 2nd Evaluation: ____/____/____ Time of 2nd Evaluation: __:____

Symptoms Observed:	**First Doctor Visit**		**Second Doctor Visit**	
Dizziness	YES	NO	YES	NO
Headache	YES	NO	YES	NO
Tinnitus	YES	NO	YES	NO
Nausea/Vomiting	YES	NO	YES	NO
Fatigue	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

First Doctor Visit: Has the athlete suffered a concussion? **YES** **NO**

Additional Findings/Comments/Concerns: _____

_____

Recommendations/Limitations: _____

_____

Signature: _____ Date: ____/____/____

Second Doctor Visit:

Is the athlete asymptomatic and ready to begin the return to play progression? **YES** **NO**

Is the athlete still symptomatic and in need of referral to a concussion specialist? **YES** **NO**

Signature: _____ Date: ____/____/____