SOUTH HUNTINGTON SCHOOL DISTRICT
Huntington Station, New York 11746

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.:____________

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NAME ______________________ D.O.B.__________________

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.

Diagnosis: ____

Additional Findings/Comments:

____

____

Recommendations/Limitations:

____

____

Signature and Stamp: ______________________ Date: __________

Final Determination and Return to Physical Education and Sports:
Is the athlete ready to return to activity? (Yes or No)
Additional Findings/Comments:

____

____

Signature: ______________________________ Date: ____________

School Physician Signature: ____________________ Date: ____________

SOUTH HUNTINGTON SCHOOL DISTRICT
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NAME ______________________________ D.O.B. ______________________

Neurologist 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.

Diagnosis: ____

Additional Findings/Comments:

____

____

Recommendations/Limitations:

____

____

Signature and Stamp: ______________________ Date: ______________

Final Determination and Return to Physical Education and Sports:
Is the athlete ready to return to activity? (Yes or No)
Additional Findings/Comments:

____

____

Signature: ______________________________ Date: ______________

School Physician Signature: ______________________ Date: ______________