_____ **Schools**

STUDENT
CONCUSSION CHECKLIST
Physician Evaluation

To be completed by Student athlete's primary care Physician or ER Physician ONLY

Date of First Evaluation: _____ **Time of Evaluation:** _____

Date of Second Evaluation: **Time of Evaluation:** _____

***PLEASE INDICATE YES OR NO IN YOUR RESPECTIVE COLUMNS.**

Symptoms Observed:	**First Doctor Visit**		**Second Doctor Visit**	
Vertigo	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
Photophobia	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: **(one or the other must be circled)**

Did you review the "Initial Concussion Checklist" provided by the

Athletic Trainer or Coach/Nurse?	Yes	No
Did the student sustain a concussion?	Yes	No
Positive finding on neurological exam?	Yes	No

Additional Findings/Comments: _____

_____

Recommendations/Limitations: _____

NOTE: M.D. clearance to participate trigger the start of B.C.S.'s return to play procedure.

Physician's Signature _____ Date_____

Print Physician's Name _____ Phone Number _____

Second Doctor Visit:

Please check one of the following:

- O Student is asymptomatic and is ready to begin the return to play/activity progression.
- O Student is still symptomatic after seven days. Must be referred to a concussion specialist/clinic.

Physician's Signature _____ Date_____

Print Physician's Name _____ Phone Number _____

Evaluator's Signature: _____ Title: _____

Address: _____Date: _____ Phone #: _____

ER Attendant Signature: _____ Print Name: _____

Primary M.D. Signature: _____ Print Name: _____