DC WEST STUDENT-ATHLETE CONCUSSION FORM

ATHLETE'S NAME:_____ DOB:_____ TODAY'S DATE: _____

CURRENT SPORT:_____ INJURY DATE/TIME: _____ BASELINE TEST_____
PREVIOUS HEAD INJURY: Y/N PARENT CONTACTED: _____
CURRENT INCIDENT:

SIGNS OBSERVED BY COACH/PARENT/ATC

- ☐ DAZED/CONFUSED
- ☐ LACK OF COORDINATION
- ☐ POOR REACTION TIME
- ☐ LOSS OF CONSCIOUSNESS
- ☐ RETROGRADE AMNESIA
- ☐ PUPILS ARE NOT EQUAL/REACTIVE
- ☐ VOMITING
- ☐ PHOTOPHOBIA

SYMPTOMS REPORTED BY ATHLETE:

- ☐ HEADACHE
- ☐ DIZZINESS/ BALANCE
- ☐ NAUSEA
- ☐ FATIGUE
- ☐ FEELING FOGGY
- ☐ FEELING SLUGGISH
- ☐ SENSITIVITY TO LIGHT/NOISE
- ☐ MEMORY/CONCENTRATION
- ☐ VISION PROBLEMS

☐ ATHLETIC TRAINER IS REFFERING TO PHYSICIAN _____ Stephannie Maca, ATC

PHYSICIAN/LICENSED HEALTH CARE PROVIDER REPORT

_____ Athlete is cleared to begin the DC West medically supervised return to play progression and may return to practice/competition according to DC West concussion guidelines.

_____Athlete may not return to any activity until after my next examination

DIAGNOSIS:_____

RECOMMENDATIONS: _____

_____

Signature: _____

Office name & Phone:_____

The athlete MUST follow up with the Athletic Trainer and will be restricted from participating until cleared by a licensed healthcare professional to begin a return to play progression. Athletes will not be allowed to return to athletic activity until signed off by Athletic Trainer & parent/guardian. NEBRASKA LAW 71-9104