Sideline Concussion Documentation: To be completed by coaching staff

Athlete's name: _____ **Date of birth:** ___ /___ /___ **Age/grade:** ___ /___

OBSERVATIONS

Team: _____ Date: ___ /___ /___ Venue: _____ Current time: _____

Time of injury: _____ Documentation completed by: _____ Phone : _____

❑ Coach ❑ Athletic trainer ❑ Parent ❑ Other: _____

If an athlete reports one or more symptoms of concussion after a bump, blow or jolt to the head or body, he or she should be kept out of play the day of the injury and until a physician, experienced in evaluating for concussion, says he or she is symptom-free and it's OK to return to play.

1. Danger signs: call 911 immediately

- ❑ Loses consciousness (even a brief loss of consciousness should be taken seriously). Duration of loss of consciousness:_____
- ❑ Is drowsy or cannot be awakened
- ❑ A headache that not only does not diminish, but gets worse
- ❑ Weakness, numbness or decreased coordination
- ❑ Repeated vomiting or nausea
- ❑ Slurred speech
- ❑ Convulsions or seizures
- ❑ Cannot recognize people or places
- ❑ Becomes increasingly confused, restless or agitated
- ❑ Has unusual behavior
- ❑ One pupil is larger than the other (if not a normal state for the athlete)

2. Injury description: ❑ Fall ❑ Hit head on other player ❑ Hit head on ground/object ❑ Struck by object

3. Location of impact: ❑ Front ❑ Back ❑ Right side ❑ Left side

4. Last memory before the impact: _____

(Duration of time between memory and impact: _____)

5. First memory after the impact: _____

(Duration of time between impact and memory: _____)

FUNCTION

1. Oriented to: ❑ self ❑ location ❑ score ❑ opponent ❑ last play

2. Does athlete stagger, sway, stumble or appear uncoordinated? ❑ Yes ❑ No

3. Are athlete's eyes having difficulty tracking, and/or do pupils look unequal? ❑ Yes ❑ No

4. Does athlete seem dazed or appear to be responding slowly or acting differently than usual? ❑ Yes ❑ No

MONITORING SYMPTOMS

Ask athlete to rate each symptom immediately after the injury, 15 minutes after, and 30 minutes after, using a scale of 0 to 3:

- 0 – none
- 1 – a little
- 2 – medium
- 3 – a lot

Enter the rating in each box for each symptom at the time intervals listed.

Symptom	Immediately	15 min after	30 min after
Headache			
Dizziness			
Vision changes			
Light sensitivity			
Noise sensitivity			
Neck pain			
Feeling distracted			
Fatigue			
Tingling/loss of movement			
Feeling foggy/cloudy/out of it			
Difficulty remembering			
Upset/emotional			

This information is provided by Providence Health & Services and our sports concussion specialists.

To make an appointment at Providence Saint Joseph Concussion Management Clinic, call 818-847-6048.
providence.org/saintjoseph

PROVIDENCE Health & Services

RCA15-45170A

Athlete's name: _____ **Date of birth:** ___ /___ /___ **Age/grade:** ___ /___

Dear Physician,

This athlete has been referred to you due to a suspected concussion sustained during play. Please evaluate this athlete to determine if he or she has sustained a concussion, review the graduated, step-wise return-to-participation progression below, and make your medical recommendations. Thank you for your assistance.

Additional information can be found at: www.cdc.gov/headsup/providers

Have you determined that this athlete sustained a concussion?
❑ No (skip to bottom of page and sign) ❑ Yes (next section)

GRADUATED, STEP-WISE RETURN-TO-PARTICIPATION PROGRESSION

These steps should be completed as recommended by your medical team and may vary by athlete.

Baseline: No symptoms. The athlete needs to have completed physical and cognitive rest and not be experiencing concussion symptoms for a minimum of 48 hours.

Physician release must be obtained before progressing to step 1.

Step 1: Light aerobic activity. *The goal:* to increase an athlete's heart rate. *The time:* five to 10 minutes. *The activities:* exercise bike, walking or light jogging. Absolutely no weight lifting, jumping or hard running.

Before progressing to the next stage, the athlete must be healthy enough to return to school full time.

Step 2: Moderate activity. *The goal:* limited body and head movement. *The time:* reduced from typical routine. *The activities:* moderate jogging, brief running, moderate-intensity stationary biking and moderate-intensity weight lifting.

Step 3: Heavy, non-contact activity. *The goal:* more intense but non-contact. *The time:* close to typical routine. *The activities:* running, high-intensity stationary biking, the player's regular weight-lifting routine and non-contact, sport-specific drills. This stage may add some cognitive component to practice in addition to the aerobic and movement components introduced in Steps 1 and 2.

Step 4: Practice and full contact. *The goal:* reintegrate in full-contact practice.

Step 5: Competition. *The goal:* return to competition.

The athlete should spend a minimum of one day at steps 2-5. If symptoms recur, the athlete must stop the activity, rest for at least 24 hours and then resume activity one step **below** where he or she was. **A graduated return applies to all activities, including academics, electronics, sports, riding bikes, physical education classes, chores, playing with friends, etc.**

THIS SECTION TO BE COMPLETED BY PHYSICIAN

❑ This athlete **may NOT return** to any sport activity until medically cleared.

❑ Athlete should **remain home from school** to rest and recover until next follow-up with physician on _____ (date).

❑ Please **allow classroom accommodations,** such as extra time on tests, a quiet room to take tests and a reduced workload when possible. Additional recommendations: _____

_____

❑ Athlete **may begin a graduated return at the stage circled above.**

❑ Athlete **must return for clearance before proceeding to Step 4.**

Physician's signature: _____ **Date:** _____

Physician's name (print): _____