EAST GREENBUSH CENTRAL SCHOOL DISTRICT
Head Injury Evaluation

Name of Student_____ DOB _____
Injury Date_____ Sport_____

Physician Evaluation

Date of First Evaluation:_____ Time of Evaluation:_____
Date of Second Evaluation:_____Time of 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	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
Anterograde Amnesia (after impact)	Yes No	N/A N/A
Retrograde Amnesia (backwards in time from impact)	Yes No	N/A N/A

First Doctor Visit:

Did the athlete sustain a concussion? (Yes or No) (one or the other must be circled)
** Post-dated releases will not be accepted. The athlete must be seen and released on the same day.

Is this the student's first concussion? (Yes or NO)
Please note that if there is a history of previous concussion, then referral for professional management by a specialist or concussion clinic should be strongly considered.

Additional Findings/Comments_____
and/or Diagnostic Tests:
Recommendations/Limitations:_____

MD Signature:_____ Date:_____
MD Print or stamp name: Phone number:_____

Second Doctor Visit:

*** Athlete must be completely symptom free in order to begin the two step return to play. If athlete still has symptoms more than seven days after injury, referral to a concussion specialist/clinic should he strongly considered.

Please check one of the following:
____Athlete is asymptomatic and is ready to begin the two step return to play.
____Athlete is still symptomatic more than seven days after injury.

MD Signature:_____ Date:_____
MD Print or stamp name: Phone number:_____