Suspected Concussion Report

Today s Date:
Player Name:
Date of Birth:
Age:
Parent(s) Name:

Phone Number:
Date of Injury:
Time of Injury:

Signs and/ or Symptoms

Signs Observed by Coaching Staff

☐Appears dazed or stunned
☐Confused about assignment or position
☐Forgets an instruction
☐Is unsure of game, score, or opponent
☐Moves clumsily
☐Answers questions slowly
☐Loses consciousness
☐Shows mood/behavior/personality change
☐Can't recall events prior/after hit or fall

Reported by Athlete

☐Headache or "Pressure" in head
☐Nausea or vomiting
☐Balance problems or dizziness
☐Double or blurry vision
☐Sensitivity to light
☐Sensitivity to Noise
☐Feeling sluggish, hazy, foggy, or groggy
☐Concentration or memory problems
☐Confusion
☐Does not "Feel Right" or "Feeling Down"

Description/Mechanism of Injury:

Previous concussion? **Yes** **No**
If yes, when? Previous ImPACT Test? **Yes** **No**

Report Completed by:

Printed Name:

Phone Number:

Dear Parent/Guardian:
Your child has been temporarily removed from all sports activities of PYLAX due to the possibility of a concussion. Based upon the evaluation of your child, using recommended policies and procedures
for the recognition of potential concussions, your child will not be allowed to return to any PYLAX practices or games until medically "cleared" to return to physical activity by a health care professional experienced in evaluating concussions.
It is recommended that a healthcare professional experienced in evaluating concussions, evaluates your child as soon as possible. Please review this report with the healthcare professional.

Print name of Parent/Guardian:

Signature:

Date: