Concussion Signs and Symptoms Checklist

Student's Name: ________________________________________________

Student's Grade: ______________________

Date/Time of Injury: _____________________________________________

Where and How Injury Occurred: (Be sure to include cause and force of the hit or blow to the head.)
______________________________________________________________________
______________________________________________________________________

Description of Injury: (Be sure to include information about any loss of consciousness and for how long, memory loss, or seizures following the injury, or previous concussions, if any. See the section on Danger Signs on the back of this form.)
______________________________________________________________________
______________________________________________________________________

DIRECTIONS:
Use this checklist to monitor students who come to your office with a head injury. Students should be monitored for a minimum of 30 minutes. Check for signs or symptoms when the student first arrives at your office, fifteen minutes later, and at the end of 30 minutes.

Students who experience one or more of the signs or symptoms of concussion after a bump, blow, or jolt to the head should be referred to a health care professional with experience in evaluating for concussion. For those instances when a parent is coming to take the student to a health care professional, observe the student for any new or worsening symptoms right before the student leaves. Send a copy of this checklist with the student for the health care professional to review.

SIGNS AND SYMPTOMS
_____ Is confused about events
_____ Repeats questions
_____ Answers questions slowly
_____ Can’t recall events prior to the hit, bump, or fall
_____ Can’t recall events after the hit, bump, or fall
_____ Loses consciousness (even briefly)
_____ Shows behavior or personality changes
_____ Forgets class schedule or assignments

PHYSICAL SYMPTOMS
_____ Headache or “pressure” in head
_____ Nausea or vomiting
_____ Balance problems or dizziness
_____ Fatigue or feeling tired
_____ Blurry or double vision
_____ Sensitivity to light
_____ Sensitivity to noise
_____ Numbness or tingling
_____ Does not “feel right”

COGNITIVE SYMPTOMS
_____ Difficulty thinking clearly
_____ Difficulty concentrating
_____ Difficulty remembering
_____ Feeling more slowed down
_____ Feeling sluggish, hazy, foggy, or groggy

EMOTIONAL SYMPTOMS
_____ Irritable
_____ Sad
_____ More emotional than usual

Additional Information about This Checklist:

This checklist is also useful if a student appears to have sustained a head injury outside of school or on a previous school day. In such cases, be sure to ask the student about possible sleep symptoms. Drowsiness, sleeping more or less than usual, or difficulty falling asleep may indicate a concussion.

To maintain confidentiality and ensure privacy, this checklist is intended only for use by appropriate school professionals, health care professionals, and the student’s parent(s) or guardian(s).

Resolution of Injury:

_____ Student returned to class
_____ Student sent home
_____ Student referred to health care professional with experience in evaluating for concussion

__________________________________________________________
_______SIGNATURE OF SCHOOL PROFESSIONAL COMPLETING THIS FORM:
TITLE:_____________________________________

COMMENTS:

Reference:  U.S. Department of Health and Human Services Centers for Disease Control and Prevention