

STUDENT-ATHLETE CONCUSSION FORM

OMAHA PUBLIC SCHOOLS– SECONDARY EDUCATION

ATHLETE'S NAME _____ DOB: _____

TODAY'S DATE _____ INJURY DATE: _____

CURRENT SPORT: _____ SCHOOL: _____

PREVIOUS HEAD INJURY? YES/NO

CURRENT INCIDENT _____

SIGNS OBSERVED BY ATC/COACH

- ◇ DAZED/CONFUSED
- ◇ LACK OF COORDINATION
- ◇ POOR REACTION TIME
- ◇ LOSS OF CONSCIOUSNESS
- ◇ RETROGRADE AMNESIA
- ◇ PUPILS EQUAL AND REACTIVE TO LIGHT
- ◇ NYSTAGMUS
- ◇ SENSITIVE TO LIGHT/NOISE
- ◇ VOMITING

SYMPTOMS REPORTED BY ATHLETE

- ◇ HEADACHE
- ◇ DIZZINESS/ BALANCE PROBLEMS
- ◇ NAUSEA
- ◇ FATIGUE
- ◇ FEELING FOGGY
- ◇ FEELING SLUGGISH
- ◇ SENSITIVE TO LIGHT/NOISE
- ◇ MEMORY/CONCENTRAITION ISSUES
- ◇ VISION PROBLEMS

_____ ATHLETIC TRAINER IS REFERRING TO PHYSICIAN

OPS ATHLETIC TRAINER

DATE: _____

CONTACT PHONE: _____

PHYSICIAN/LICENSED HEALTH CARE PROVIDER REPORT

CONCUSSION DIAGNOSIS? YES/NO

RECOMMENDATIONS: _____

FOLLOW UP APPOINTMENT _____

PHYSICIAN/APPROVED HEALTH CARE PROVIDER SIGNATURE: _____

OFFICE NAME & PHONE: _____

IF ATHLETE IS SEEN BY A PHYSICIAN/HEALTH CARE PROVIDER THIS SECTION MUST BE FILLED OUT AND RETURN TO ATHLETIC TRAINER

***The athlete MUST follow up with their school's athletic trainer daily. The athlete will be restricted from participating until cleared by a licensed health care provider and a return to sport protocol has been completed with the athletic trainer.**

GUIDELINES FOR HOME CONCUSSION MANGEMENT

ATHLETE **MUST** CHECK IN EVERY DAY WITH THE SCHOOLS NURSE & ATHLETIC TRAINER FOLLOWING CONCUSSION

PLEASE REPORT TO EMERGENCY ROOM IF ATHLETE :

- HEADACHE INTENSIVIES
- HAS A SEIZURE
- LOOKS VERY DROWSY AND CAN'T BE AWAKENED
- VOMITS
- SLURRED SPEECH
- INCREASING CONFUSION
- WEAKNESS OR NUMBNESS IN LIMBS
- UNUSUAL BEHAVIOR
- LOSS OF CONSCIOUSNESS

CONCUSSION INJURY ADVICE

- * Recommended student-athlete have rest with NO interruptions
- * Student may need cognitive rest (no school) 24-48 hours post concussion
 - * Driving vehicle is NOT advised until symptoms improve
 - * Avoid prescription drugs (except daily prescribed)
- * Avoid taking aspirin or ibuprofen: these medications may thin blood
 - * It is OKAY to use acetaminophen (Tylenol) for headaches

PARENT/GUARDIAN NOTIFIED OF STUDENT AHLETES INJURY:

YES/NO: CONTACT COULD NOT BE MADE/LEFT MESSAGE

PARENT/GUARDIAN CONTACTED: _____

DATE: _____

TIME _____

Parent/guardian release to participate: I have been informed of the student-athlete's condition and understand that they have suffered a concussion. I hereby grant the student-athlete permission to return to participate in sports in accordance with the progression steps outlined by school's athletic trainer.

Signature of parent/guardian: _____

Date: _____

FOR ATHLETIC TRAINER OFFICE USE:

ATHLETE HAS COMPLETED FULL PROGRESSION WITH ATC DATE/TIME: _____

SIGNATURE: _____ DATE: _____