Team: _____ **Concussion Protocol** **Date:** _____

Personal Information

Name of Injured Person _____ Person Role: _____

DOB _____ Gender _____ Parent Name _____

Address _____ Primary Phone _____ Work Phone _____

Team _____ Division _____ Manager _____

Concusson Protocol Information

Signs Observed by Coaching Staff

Question	Answer
Appears dazed or stunned	Yes / No
Is confused about assignment or position	Yes / No
Forgets an instruction	Yes / No
Is unsure of game, score, or opponent	Yes / No
Moves cumsily	Yes / No
Answers questions slowly	Yes / No
Loses consciousness (even briefly)	Yes / No
Shows mood, behavior, or personality changes	Yes / No
Can't recall events prior to hit or fall	Yes / No
Can't recall events after hit or fall	Yes / No

Symptoms Reported by Athlete

Question	Answer
Headache or "pressure" in head	Yes / No
Nausea or vomiting	Yes / No
Balance problems or dizziness	Yes / No
Double or blurry vision	Yes / No
Sensitivity to light	Yes / No
Sensitivity to noise	Yes / No
Feeling sluggish, hazy, foggy, or groggy	Yes / No
Concentration or memory problems	Yes / No
Confusion	Yes / No
Just not "feeling right" or is "feeling down"	Yes / No

League Representative Signature / Date

Coach or Staff / Date