Sideline Concussion Documentation
To be completed by coaching staff

Athlete’s name: _________________________________________________
Date of birth: _____ / _____ / _____ Age/grade: ____ / ____

OBSERVATIONS
Team: __________________________ Date: _______________
Venue: ______________________ Current time: ____________ Time of injury: __________
Documentation completed by: _______________________ Phone #: ______________________________
☐ Coach ☐ ATC ☐ Parent ☐ Other: ___________________

1. Did loss of consciousness occur? ☐ Yes ☐ No If ‘YES,’ call 911. Duration of LOC __________
2. Were seizures observed? ☐ Yes ☐ No If ‘YES,’ call 911. Comments: _________________________
3. Was vomiting observed? ☐ Yes ☐ No If ‘YES’ and more than 1x, call 911.
4. Injury description: ☐ Fall ☐ Hit head on other player ☐ Hit head on ground/object
   ☐ Struck by object
5. Location of impact: On the head: ☐ Front ☐ Left front ☐ Right front ☐ Left back ☐ Right back ☐ Back
   Other location: ☐ Neck ☐ Indirect force
6. Last memory before the impact: __________________________________________________________
   (Duration of time between memory and impact: __________)
7. First memory after the impact: ________________________________________________________
   (Duration of time between impact and memory: __________)

FUNCTION
1. Oriented to: ☐ self ☐ location ☐ score ☐ opponent ☐ last play
2. Does athlete stagger, sway, stumble or appear uncoordinated? ☐ Yes ☐ No
3. Are athlete’s eyes having difficulty tracking, and/or do pupils look unequal? ☐ Yes ☐ No
4. Does athlete seem dazed or appear to be responding slowly or acting differently than usual?
   ☐ Yes ☐ No

Monitoring Symptoms
Ask athlete to rate each symptom immediately after the injury, 15 minutes after, and 30 minutes after, using a scale of 0 to 3:
   ▶ 0 – none
   ▶ 1 – a little
   ▶ 2 – medium
   ▶ 3 – a lot
Enter the rating in each box for each symptom at the time intervals listed.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Immediately</th>
<th>15 min after</th>
<th>30 min after</th>
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</thead>
<tbody>
<tr>
<td>Headache</td>
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<td></td>
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<tr>
<td>Dizziness</td>
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<td>Vision changes</td>
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<td>Light sensitivity</td>
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<tr>
<td>Noise sensitivity</td>
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<td>Neck pain</td>
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<tr>
<td>Feeling distracted</td>
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<td></td>
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<tr>
<td>Fatigue</td>
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<td></td>
<td></td>
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<tr>
<td>Tingling/loss of movement</td>
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<tr>
<td>Feeling foggy/cloudy/out of it</td>
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<td>Difficulty remembering</td>
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<tr>
<td>Upset/emotional</td>
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</tbody>
</table>

Information provided by Providence Sports Care Center:
Dear Physician,

This athlete has been referred to you due to a suspected concussion sustained during play. Please evaluate this athlete to determine if he/she sustained a concussion, review the graduated, step-wise return-to-participation progression below, and make your medical recommendations. Thank you for your assistance.

Additional information can be found at: www.cdc.gov/concussion/HeadsUp/physicians_tool_kit.html

Have you determined that this athlete sustained a concussion?

- [ ] No (skip to bottom of page and sign)  - [ ] Yes (next section)

**GRADUATED, STEP-WISE RETURN-TO-PARTICIPATION PROGRESSION**

1. **No activity:** Complete rest, both physical and cognitive. This may include staying home from school or limiting school hours and/or homework since activities requiring concentration and attention may worsen symptoms and delay recovery.

2. **Light aerobic exercise:** Low-intensity walking or stationary bike riding; no weight lifting or resistance training. Before progressing to the next stage, athlete must be healthy enough to return to school full time.

3. **Sport-specific exercise:** Begin sprinting, dribbling basketball or soccer ball, etc.; no helmet or equipment, no head-impact activities.

4. **Non-contact training:** Begin more complex drills in full equipment, weight training or resistance training. Physician release must be obtained before progressing to Steps 5 and 6.

5. **Full-contact practice:** Participate in normal training activities.

6. **Unrestricted return-to-participation/full competition** (also complete “Return to Participation” form)

The athlete should spend a minimum of one day at each step. If symptoms recur, the athlete must stop the activity, rest for at least 24 hours and then resume activity one step below where he/she was. A graduated return applies to all activities, including academics, electronics, sports, riding bikes, PE classes, chores, playing with friends, etc.

**THIS SECTION TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROFESSIONAL**

- [ ] This athlete may NOT return to any sport activity until medically cleared.

- [ ] Athlete should remain home from school to rest and recover until next follow up with physician on _______________________ (date).

- [ ] Please allow classroom accommodations, such as extra time on tests, a quiet room to take tests, and a reduced workload when possible. Additional recommendations: __________________________

- [ ] Athlete may begin a graduated return at the stage circled above.

**Physician/health care professional’s signature:** ____________________  Date: ____________

**Physician/health care professional’s name/title (print):** __________________________________________

www.ProvidenceOregon.org/HealthyKids