



▲ IF ATHLETE IS UNRESPONSIVE, SEIZING, OR CANNOT WALK — CALL 911 IMMEDIATELY ▲

CONFIDENTIAL. Complete this form immediately after any suspected head injury. Retain in athlete medical file for a minimum of seven (7) years.

SECTION 1 · INCIDENT INFORMATION

Date of Incident _____ Time _____ AM PM Report Completed _____

Location / Venue _____

Sport / Activity _____ Opposing Team _____

Practice or Game Practice Game Scrimmage Other Surface / Field Type _____

SECTION 2 · ATHLETE INFORMATION

Athlete Full Legal Name _____ Date of Birth _____ Age _____

School / Organization _____ Grade _____ Jersey/ID # _____

Parent / Guardian Name _____ Emergency Phone _____

Prior Concussion History None 1 Prior 2 Prior 3+ Unknown Most Recent _____

SECTION 3 · MECHANISM OF INJURY

Check all that apply.

- Helmet-to-Helmet contact
- Elbow / Knee / Shoulder to Head
- Head-to-Ball
- Whiplash / rapid head rotation
- Head-to-Ground / Fall
- Head-to-Goalpost, Wall, or Board
- Body contact — indirect force to head
- Unknown mechanism

Describe exactly what happened impact direction, player positions, and relevant context

Was athlete wearing protective headgear? Yes — Type _____ No

Witnesses present? Yes — Name & Contact _____ No



SECTION 4 · SIGNS & SYMPTOMS OBSERVED

RED FLAGS Any of these = activate EMS immediately.

- | | | |
|--|---|---|
| <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Seizure / Convulsions | <input type="checkbox"/> Cannot walk normally |
| <input type="checkbox"/> Repeated vomiting | <input type="checkbox"/> Unequal pupils | <input type="checkbox"/> Increasing confusion / agitation |
| <input type="checkbox"/> Slurred speech | <input type="checkbox"/> Extreme drowsiness / cannot wake | <input type="checkbox"/> Neck pain with arm numbness |

Duration of Loss of Consciousness None < 30 sec 30 sec – 1 min > 1 min (call EMS)

General Symptoms check all that are present

- | | | |
|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pressure in head | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Double vision | <input type="checkbox"/> Light sensitivity |
| <input type="checkbox"/> Noise sensitivity | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Balance problems |
| <input type="checkbox"/> Feeling slowed | <input type="checkbox"/> Feeling foggy | <input type="checkbox"/> Poor concentration |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Confusion | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Drowsiness | <input type="checkbox"/> More emotional | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Sadness / Anxiety | <input type="checkbox"/> Numbness / Tingling | <input type="checkbox"/> Feeling 'not right' |

Other symptoms not listed

Amnesia (memory loss)? Pre-event amnesia Post-event amnesia No amnesia observed



SECTION 5 · IMMEDIATE ACTIONS TAKEN

- Removed athlete from play immediately
- EMS / 911 activated
- School administration notified
- Team physician evaluated athlete
- Athlete transported to Emergency Room
- Athlete remained at facility — under observation
- Monitored athlete on-site
- Parent / Guardian notified by phone
- Athletic trainer assessed athlete
- Ice / cold compress applied
- Athlete sent home with parent
- Concussion protocol initiated

Time removed from play _____ Time parent notified _____ Time EMS called _____

Medical personnel who assessed athlete _____

Hospital / ER transported to _____

Additional actions / notes

SECTION 6 · REPORT COMPLETED BY

Reporting Staff Member (Print) _____ Signature _____

Title / Role _____ Date _____

Phone _____ Email _____

Athletic Trainer / Team Physician Confirmation _____ Signature _____

SECTION 7 · DISTRIBUTION & FOLLOW-UP CHECKLIST

Copies distributed to

- Athletic Director
- School Nurse / Health Office
- Parent / Guardian (copy given)
- Original filed in athlete medical record
- School Principal / Administrator
- Head Coach
- Treating Physician
- Treating Hospital / ER record

Physician follow-up scheduled? Yes — Date _____ No — Reason _____

Return-to-Learn accommodations initiated? Yes No — Note _____

Concussion Return-to-Play Protocol form initiated? Yes — Date _____ No

ATHLETE MUST NOT RETURN TO PLAY ON THE DAY OF INJURY. Initiate Return-to-Play Protocol before any return to activity.