

CONCUSSION EVALUATION

EVENT DATE: _____

VISITING TEAM NAME: _____

HOME TEAM NAME: _____

NAME OF STUDENT-ATHLETE INJURED: _____

NAME OF EDUCATIONAL INSTITUTION INJURED STUDENT-ATHLETE REPRESENTS: _____

WEIGHT CLASS: _____

MATCH PERIOD: 1 2 3 SUDDEN VICTORY OVERTIME (CIRCLE ONE)

TIME REMAINING IN MATCH PERIOD: _____

TIME OF DAY EVALUATION STARTED: _____

TIME EVALUATION COMPLETED: _____

TOTAL LENGTH OF TIME FOR EVALUATION: _____

WHO AUTHORIZED THE STUDENT ATHLETE TO RETURN TO COMPETITION?

NAME OF PERSON PERFORMING EVALUATION: _____

PHYSICIAN TRAINER OTHER HEALTHCARE PROFESSIONAL (CIRCLE ONE)

OFFICIAL'S NAME: _____

SIGNATURE: _____

CELL PHONE NUMBER: _____