

Regina Minor Football 2000 Inc.

Concussion Documentation Tool

Player Name:		Age:	Gender: M / F	
Date and time of injury:				
Description of the event that led to the injury (type of drill/activity, point of contact, description of contact, description of body movement – whiplash effect, head contact with ground/player, etc.):				
Immediate signs and symptoms (check any that are present):				
Signs			Symptoms	
0	Loss of consciousness		Headache	
0	Balance problems		 Pressure in the head 	
0	Uncoordinated movements		 Neck pain 	
0	Disoriented or confused		o Nausea	
0	Memory loss		 Dizziness 	
0	Blank or vacant stare		 Blurred vision 	
0	Acting differently than usual		 Feeling "slowed down" 	
			Feeling "in a fog"	
			 Don't feel right 	
1	o Confusion			
Other: Signs and symptoms within the first 24 hours (check any that are present):				
Signs		Symptoms		
0	Loss of consciousness	 Headache 		 Light sensitivity
0	Balance problems	o Pressure in	the head	 Noise sensitivity
0	Uncoordinated	 Neck pain 		 Difficulty concentrating
	movements	 Nausea 		 Difficulty remembering
0	Disoriented or confused	 Dizziness 		 Fatigue/low energy
0	Memory loss	 Blurred vision 	on	 Drowsiness
0	Blank or vacant stare	 Feeling "slo" 	wed down"	 Trouble falling asleep
0	Acting differently than	o Feeling "in a	_	 More emotional
	usual	 Don't feel ri 	ght	 Irritable
		 Confusion 		o Sad
				 Nervous or anxious
Other:				
Assessed by Dr Date and time:				
Doctor's comments (medication, further tests, etc.):				
Doctor's signature:				



Step 6- normal practice and game play

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Return To Play Documentation

Step 1 – physical and mental rest (no physical activity; no reading, homework, computer, TV, cell phone, concentration demanding activities; it is recommended that children do not attend school).

Date and time signs and symptoms were no longer present:

Step 2 (at least 24 hours following the absence of signs and symptoms) activity:

Step 3 (at least 24 hours following Step 2; complete absence of signs and symptoms) activities:

Step 4 (at least 24 hours following Step 3; complete absence of signs and symptoms) activities:

Step 5 (at least 24 hours following Step 4; complete absence of signs and symptoms; medical clearance) activities:

Medical Clearance:

Based on the details given to me on this form and my own medical assessment, this child may return to contact activities.

Doctor's Name:

Doctor's Signature:

Date:

Date:

Date: