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**
○ Loss of consciousness ○ Balance problems ○ Uncoordinated movements ○ Disoriented or confused ○ Memory loss ○ Blank or vacant stare ○ Acting differently than usual	○ Headache ○ Pressure in the head ○ Neck pain ○ Nausea ○ Dizziness ○ Blurred vision ○ Feeling "slowed down" ○ Feeling "in a fog" ○ Don't feel right ○ Confusion

Other: _____

Signs and symptoms within the first 24 hours (check any that are present)**:**

Signs	**Symptoms**	
○ Loss of consciousness ○ Balance problems ○ Uncoordinated movements ○ Disoriented or confused ○ Memory loss ○ Blank or vacant stare ○ Acting differently than usual	○ Headache ○ Pressure in the head ○ Neck pain ○ Nausea ○ Dizziness ○ Blurred vision ○ Feeling "slowed down" ○ Feeling "in a fog" ○ Don't feel right ○ Confusion	○ Light sensitivity ○ Noise sensitivity ○ Difficulty concentrating ○ Difficulty remembering ○ Fatigue/low energy ○ Drowsiness ○ Trouble falling asleep ○ More emotional ○ Irritable ○ Sad ○ Nervous or anxious

Other: _____

Assessed by Dr. _____ **Date and time:** _____

Doctor's comments (medication, further tests, etc.)**:** _____

_____

Doctor's signature: _____

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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:** _____

Step 6– normal practice and game play