Southeast Soccer Club Sideline Concussion Documentation

Athlete name: _____ Date of birth: ___/___/___ Age/Grade: ____/_____

OBSERVATIONS

Team: _____ Date: _____ Venue: _____ Current time: _____

Time of Injury: _____ Documentation completed by: _____ Phone #: _____

☐ Coach ☐ ATC ☐ Parent ☐ Other: _____

1. Loss of consciousness? ☐ Yes ☐ No **If 'YES', call 911** Duration of LOC_____
2. Were seizures observed? ☐ Yes ☐ No **If 'YES', call 911** Comments: _____
3. Was vomiting observes? ☐ Yes ☐ No **If 'YES', and more than 2x, 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 player stagger, sways, stumbles or appears uncoordinated? ☐ Yes ☐ No
3. Are player's eyes having difficulty tracking and/or do pupils look unequal? ☐ Yes ☐ No
4. Does the player seem dazed, is the player responding slowly, or acting different than usual? ☐ Yes ☐ No

Monitoring Symptoms

Ask player 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.

Symptom	Immediately	15 min after	30 min after
Headache			
Dizziness			
Vision changes			
Light sensitivity			
Noise sensitivity			
Neck pain			
Feeling distracted			
Fatigue			
Tingling/loss of movement			
Feeling foggy/cloudy/out of it			
Difficulty remembering			
Upset/emotional			

SESC Concussion Return to Participation Medical Release

Athlete name: _____ Date of birth: ___/___/___ Age/Grade: ____/_____

Dear Physician,

This athlete has been referred to you due to a suspected concussion sustained during play. Please evaluate this player to determine if player sustained a concussion, review the Graduated, Step-wise Return –to –Participation Progression below, and make recommendations as you see fit. If you determine the player has sustained a concussion, the SESC will follow your recommendations, and will not allow a player to return to full sports participation within 2 weeks of the injury (regardless of whether player is released to play by you prior to that time).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 player 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 as activities requiring concentration and attention may worsen symptoms and delay recovery.
2. **Light aerobic exercise**: Walking or stationary bike at low intensity; no weight lifting or resistance training.

Before progressing to the next stage the student must be healthy enough to return to school full time.

3. **Sport-specific exercise**: Sprinting, dribbling basketball or soccer; no helmet or equipment, no head impact activities.
4. **Non-contact training**: More complex drills in full equipment. Weight training or resistance training may begin.
5. **Full contact practice**: Participate in normal training activities.
6. **Unrestricted Return-to-Participation/full competition** (please also complete "Return to Participation" Form)

The athlete should spend a minimum of one day at each step. If symptoms re-occur, the athlete must stop the activity. The student must rest for a minimum of 24 hours and then resume activity one-step below where he or she was when the symptoms occurred. ***Graduated return applies to all activities including academics, electronics, sports, riding bikes, playing with friends, PE classes, chores, etc.***

THIS SECTION TO BE COMPLETED BY PHYSICIAN/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 graduated return at stage circled above.**

Physician/Health Care Professional Signature: _____ **Date**: _____

Physician/Health Care Professional Name/Title: _____ **Phone**:_____