

Otonabee Minor Hockey

Concussion Checklist

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Team: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**On Site Evaluation**

Description of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has the athlete ever had a concussion? Yes No

Was there a loss of consciousness? Yes No Unclear

Does he/she remember the injury? Yes No Unclear

Does he/she have confusion after the injury? Yes No Unclear

**Symptoms observed at time of injury:**

Dizziness Yes No Headache Yes No

Ringing in Ears Yes No Nausea/Vomiting Yes No

Drowsy/Sleepy Yes No Fatigue/Low Energy Yes No

“Don’t Feel Right” Yes No Feeling “Dazed” Yes No

Seizure Yes No Poor Balance/Coord. Yes No

Memory Problems Yes No Loss of Orientation Yes No

Blurred Vision Yes No Sensitivity to Light Yes No

Vacant Stare/ Sensitivity to Noise Yes No

Glassy Eyed Yes No

\* Please circle yes or no for each symptom listed above.

Other Findings/Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Final Action Taken**: Parents Notified Sent to Hospital

Evaluator’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No.: \_\_\_\_\_\_\_\_\_\_\_\_