Sideline Concussion Test

Athlete name: _____ Parish: _____

Form filled out by: _____ Coaches Signature: _____

Parent(s) Signature: _____

Symptoms (check yes or no)

symptom	Yes	No		symptom	Yes	No
Loss of consciousness				Feeling slowed down or "in a fog"		
Seizure or convulsion				"don't feel right"		
Amnesia				Difficulty concentrating		
Headache or pressure in the head				Difficulty remembering		
Neck pain				Fatigue or low energy		
Nausea or vomiting				Confusion		
Dizziness				Drowsiness		
Blurred vision				More emotional		
Balance problems				Irritability		
Sensitivity to light				Sadness		
Sensitivity to noise				Nervous or anxious		

Memory function (check whether they answered correctly or not)

Question	Answered correctly	Answered incorrectly
Where are we at today?		
Which half is it?		
Who scored last in this game?		
What team did you play last game?		
Did your team win the last game?		

Concentration test (check whether they answered correctly or not)

Question	Answered correctly	Answered incorrectly
Repeat the days of the week backwards, start with Sunday		
Repeat this number backwards: 419		

Balance Test

Have athlete stand heel to toe with hands on hips and eyes closed. Count how many times they are out of the start position (hands off hips, opening eyes, lifting a heel, stepping, falling off balance, etc) during 20 seconds.

	Less than 5	More than 5
Errors		

When completed, this form must be returned to the CYO by Mail. Fax or email:

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