|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Observed Symptoms** | **0****Minutes** | **15****Minutes** | **30****Minutes** | 45**Minutes** |
| Appears dazed or stunned |[x] [ ] [ ] [ ]
| Is confused about events |[ ] [ ] [ ] [ ]
| Repeats questions |[ ] [ ] [ ] [ ]
| Answers questions slowly |[ ] [ ] [ ] [ ]
| Can’t recall events *prior* to injury |[ ] [ ] [ ] [ ]
| Can’t recall events *after* injury |[ ] [ ] [ ] [ ]
| Loss of consciousness (even briefly) |[ ] [ ] [ ] [ ]
| Shows behavior or personality changes |[ ] [ ] [ ] [ ]
| Forgets Class schedule or assignments |[ ] [ ] [ ] [ ]
| Headache or “pressure” in head |[ ] [ ] [ ] [ ]
| Nausea or vomiting |[ ] [ ] [ ] [ ]
| Balance problems or dizziness |[ ] [ ] [ ] [ ]
| Fatigue or feeling tired |[ ] [ ] [ ] [ ]
| Blurry or double vision |[ ] [ ] [ ] [ ]
| Sensitivity to light |[ ] [ ] [ ] [ ]
| Sensitivity to noise |[ ] [ ] [ ] [ ]
| Numbness or tingling |[ ] [ ] [ ] [ ]
| Does not “feel right” |[ ] [ ] [ ] [ ]
| Difficulty thinking clearly |[ ] [ ] [ ] [ ]
| Difficulty concentrating |[ ] [ ] [ ] [ ]
| Difficulty remembering |[ ] [ ] [ ] [ ]
| Feeling more slowed down |[ ] [ ] [ ] [ ]
| Feeling sluggish, hazy, foggy or groggy |[ ] [ ] [ ] [ ]
| Irritable |[ ] [ ] [ ] [ ]
| Sad |[ ] [ ] [ ] [ ]
| More emotional than usual |[ ] [ ] [ ] [ ]
| Nervous |[ ] [ ] [ ] [ ]

**Signature of School Staff Member completing this form:**

Title: Date:

**Parent Signature:**

Date:

**Directions:** If at any time during assessment the student develops one or more of the symptoms listed on the ***Head Injury Danger Signs Checklist*** refer the child immediately for emergency medical care.

To complete the ***Concussion Signs and Symptoms Checklist*** interview the student and assess for the symptoms of concussion listed in the “Observed Symptoms” column. Place a check mark for each symptom observed in the column marked “0 Minutes” next to the symptom observed. If one or more of the boxes are checked after the initial observation, contact the parent/guardian as the student should be referred to a health care professional with experience in evaluating for concussion. Continue to monitor the student using the checklist until the parent/guardian arrives. If the student shows no observed symptoms after the initial completion of the checklist at 0 minutes, continue to administer the checklist at 15 minutes after the initial observation and again 30 minutes after the initial observation. If during any of these subsequent observations one or more symptoms of concussion is observed, contact the parent/guardian as the student should be referred to a health care professional with experience in evaluating for concussion. If after thirty minutes the student shows no symptoms of concussion, the student may be returned to class.

**CONCUSSION SIGNS AND SYMPTOMS CHECKLIST**

**STUDENT NAME:** Click here to enter text. **DATE:** Click here to enter a date. **TIME:** Click here to enter text.