Port Chester-Rye Union Free School District
113 Bowman Avenue
Port Chester, New York 10573
914.934.7913

Concussion Management Protocol

Head Injury Evaluation Checklist On Site Evaluation Form

PART A

Student Name: _____ Age: _____ Grade: _____ D.O.B. _____

Activity/Sport: _____ Date of Injury: _____ Time: _____ Location: _____

Description of injury and how it occurred: _____

Was there a loss of consciousness?	☐ Yes	☐ No	☐ Unclear
Does he/she remember the injury?	☐ Yes	☐ No	☐ Unclear
Did he/she have confusion after the injury?	☐ Yes	☐ No	☐ Unclear

SYMPTOMS OBSERVED AT TIME OF INJURY: **Please Circle**

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	Yes	No
Memory problems	Yes	No	Loss of orientation	Yes	No
Blurred vision	Yes	No	Sensitivity to light	Yes	No
Vacant stare	Yes	No	Glassy eyed	Yes	No

Other findings/comments: _____

Actions Taken:
- ☐ Parents notified*
- ☐ Health office notified*
- ☐ Ambulance called
- ☐ Taken to doctor by parent*
- ☐ Incident Report completed*
- ☐ Sent to hospital

*=required actions

Person completing this form (print name): _____

Signature: _____ Title: _____

Address: _____

Phone: _____ Date: _____

PCHS Health Office Fax: (914) 937-2676
JFK Elementary Main Office Fax: (914)939-6625
Edison Elementary Main Office Fax: (914)934-7980

PCMS Health Office Fax: (914) 934-7886
King Street Elementary Main Office Fax: (914)939-9351
Park Avenue Elementary Main Office Fax: (914)939-9243