GILROY HIGH SCHOOL – SUSPECTED HEAD INJURY FORM

750 WEST 10TH STREET
GILROY, CALIFORNIA 95020

(408) 847-2424
FAX – (408) 848-5627

STUDENT NAME_____ DOB _____ DATE OF INCIDENT_____

HOW INJURY OCCURRED _____

_____ TIME OF INJURY_____

1. Evaluation of Physical Signs and Symptoms of a suspected Head Injury: (Check all present)

SIGNS OBSERVED BY STAFF		SYMPTOMS REPORTED BY STUDENT	
Appears dazed or stunned		Headache or "pressure" in head (1-10 scale)	
Is confused about assignment or position		Nausea	
Forgets and instruction		Balance problems or dizziness	
Is unsure of game, score, or opponent		Double or blurry vision	
Moves clumsily		Sensitivity to light	
Answers questions slowly		Sensitivity to noise	
Mood, behavior, or personality changes		Feeling sluggish, hazy, foggy headed, or groggy	
Can't recall events *prior* to hit or fall		Concentration or memory problems	
Can't recall events *after* hit or fall		Not "feeling right", "feeling down"	

SEEK IMMEDIATE MEDICAL ATTENTION FOR THE FOLLOWING SIGNS AND SYMPTOMS

Loss of consciousness		Severe headache	
Appears very drowsy; difficult to awaken		Slurring of speech	
Bleeding or clear fluid from the ears or nose		Unequal or dilated pupils, or non-reactive to light changes	
Convulsions or seizures		Vomiting	
Severe neck pain (*Immobilize student-place on back board if available)*		Significant irritability	
Weakness or inability to move one or more limbs		Initial improvement followed by worsening symptoms	

2.Mental Status Evaluation: Perform in order. Any inability for student to respond correctly is considered abnormal- Record as "F" (Fail)

1. Orientation (Adapt questions according to circumstances)		**3. Retrograde Amnesia (Memory before the event)- Ask the student the following questions (Adapt as necessary):**	
A. What period/quarter/half are we in?		A. Do you remember the hit/fall?	
B. What city is this?		B. What happened in the play/activity prior to the hit/fall?	
C. Who is the opposing team?		C. What happened in the quarter/period/activity prior to the hit/fall?	
D. Who scored last?		D. What was the score of the game prior to the hit?	
2. Anterograde Amnesia (Memory after the event)		**4. Concentration- ask the student to do the following**	
Ask the student to repeat and remember the following words: GIRL, DOG, GREEN		A. Repeat the days of the week backwards (starting with today)	
		B. Repeat the months of the year backwards (starting with Dec.)	
		C. Repeat these numbers backwards 63 (36), 419 (914)……	
		5. Word List Memory: Ask student to repeat the 3 words from question 2	

Your son/daughter requires an M.D. or D.O. evaluation: Your son/daughter sustained a suspected head injury and needs medical attention. He/she may not return to sports and should limit physical activity until cleared by an M.D. or D.O. and the Physician's Order form is completed and returned to GHS Nurse/Athletic Trainer.

X_____ DATE/TIME _____
(SIGNATURE OF STAFF MEMBER WHO COMPLETED CHECKLIST)

X_____ DATE/TIME _____
(SIGNATURE OF STAFF MEMBER WHO NOTIFIED PARENT/GAURDIAN)
(STAFF MEMBER PLEASE TAKE A PICTURE OF THIS FORM PRIOR TO GIVING TO PARENT/STUDENT)

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PHYSICIAN ORDERS FOR DIAGNOSIS AND MANAGEMENT OF HEAD INJURIES

THIS FORM CAN BE SIGNED ONLY BY A MEDICAL DOCTOR (M.D.) OR A DOCTOR OF OSTEOPATHY (D.O.)

Student's Name _____ DOB: _____ Date of Injury: _____

(Description of head injury incident and student's symptoms must accompany this document to physician)

INJURY STATUS	*Exam Date:* _____
__	Has been diagnosed by a MD/DO with a concussion and is under our care. Medical follow-up evaluation is scheduled for *(date)*: _____
__	Was evaluated and did not have a concussion injury. There are no limitations on school and physical activity.

ACADEMIC ACTIVITY STATUS *(Please mark all that apply)*	
__	This student is not to return to school.
__	This student may begin a return to school based on successful progression through the *CIF Concussion Return to Learn Protocol*. This student requires the necessary school accommodations set forth on the *Physician (MD/DO) Recommended School Accommodations Following Concussion* form.
__	This student is no longer experiencing any signs or symptoms of concussion and may be released to full academic participation.
Comments:	_____

PHYSICAL ACTIVITY STATUS *(Please mark all that apply)*	
__	This student is not to participate in physical activity of any kind.
__	This student is not to participate in recess, PE class, or other physical activities except for untimed, voluntary walking.
__	This student may begin a monitored, graduated return to play progression (per *CIF Concussion RTP Protocol*).
__	This student is cleared for full, unrestricted athletic participation (has completed the *CIF Concussion RTP Protocol*).
Comments:	_____

TO BE COMPLETED BY PHYSICIAN: I am a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.) trained in the management of concussions and have evaluated the above student, acting within the scope of my practice.

Physician *(MD/DO)* Signature: _____ **Date:** _____

Physician Stamp and Contact Info:

TO BE COMPLETED BY PARENT/GUARDIAN: I give my consent for the school nurse/Athletic Trainer to communicate with the physician concerning issues related to my student's head injury.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____