

Physician Evaluation
(Revision #3)

Date of First Evaluation: _____ Time of Evaluation: _____

Date of Second Evaluation: _____ Time of Evaluation: _____

Symptoms Observed:	First Doctor Visit		Second Doctor Visit	
Dizziness	Yes	No	Yes	No
Headache	Yes	No	Yes	No
Tinnitus	Yes	No	Yes	No
Nausea	Yes	No	Yes	No
Fatigue	Yes	No	Yes	No
Drowsy/Sleepy	Yes	No	Yes	No
Sensitivity to Light	Yes	No	Yes	No
Sensitivity to Noise	Yes	No	Yes	No
Anterograde Amnesia (after impact)	Yes	No	N/A	N/A
Retrograde Amnesia (backwards in time from impact)	Yes	No	N/A	N/A

* Please indicate yes or no in your respective columns. First Doctor use column 1 and second Doctor use column 2.

First Doctor Visit:

Did the athlete sustain a concussion? (Yes or No) (one or the other must be circled)

** Post-dated releases will not be accepted. The athlete must be seen and released on the same day.

Please note that if there is a history of previous concussion, then referral for professional management by a specialist or concussion clinic should be strongly considered.

Additional Findings/Comments: _____

Recommendations/Limitations: _____

Signature: _____ Date: _____

Print or stamp name: _____

Phone number: _____

Second Doctor Visit:

*** Athlete must be completely symptom free in order to begin the return to play progression. If athlete still has symptoms more than seven days after injury, referral to a concussion specialist/clinic should be strongly considered.

Please check one of the following:

- Athlete is asymptomatic and is ready to begin the return to play progression.
- Athlete is still symptomatic more than seven days after injury.

Signature: _____ Date: _____

Print or stamp name: _____

Phone number: _____

Adoption Date: June 4, 2012