Ballston Spa

Educating Everyone Takes Everyone

CENTRAL SCHOOL DISTRICT

# Post Head Injury Physician Evaluation

**Student:** _____ **Date of Physician Evaluation:** _____

**Date of head injury:** _____ **Time of Evaluation:** _____

***Return to School Nurse for approval by BSCSD Medical Director***

## 1. *Symptoms Reported:* at time of injury

| | | | | | |
|---|---|---|---|---|---|
| Dizziness | Yes | No | Difficulty concentrating | Yes | No |
| Headache | Yes | No | Sensitivity to Light | Yes | No |
| Tinnitus | Yes | No | Emotional | Yes | No |
| Nausea | Yes | No | Amnesia | Yes | No |
| Fatigue | Yes | No | (Anterograde/Retrograde) | | |

## 2. *Clinical Evaluation:*

| | | | |
|---|---|---|---|
| Cognition | WNL | Impaired | Not Assessed |
| Balance | WNL | Impaired | Not Assessed |
| Pupils | PERRL | Abnormal | Not Assessed |
| Oculomotor screening | WNL | Increased symptoms/Nystagmus | Not Assessed |

## 3. *Diagnosis:* _____

(a diagnosis of concussion, head injury, closed head injury, head trauma, or similar will still follow post-head injury protocols)

## 4. *Plan:*

a. **Student must be completely symptom free in order to begin the return to play progression.**

b. **Please note that if there is a history of previous concussion or symptoms last longer than 10 days, then referral for professional management by a specialist or concussion clinic should be strongly considered.**

c. Academic Accommodations: _____

_____

d. Physical Activity Restrictions:

- ☐ No physical activity (No PE credit)
- ☐ May walk only at PE until symptom free/No Athletic participation
- ☐ May begin graduated return to activity per BSCSD protocol
- ☐ May resume full contact-activity, **NOT A CLOSED HEAD INJURY** (please provide a diagnosis)

Physician's Stamp:

Signature: _____

Date: _____