

CYO Sideline Concussion Test

Athlete Name: _____

Parish: _____

Form filled out by: _____

Coaches Signature: _____

SYMPTOMS (check **yes** or **no**)

Parent(s) Signature: _____

Symptoms	Yes	No	Symptoms	Yes	No
Loss of consciousness			Feeling slowed down or 'in a fog'		
Seizure or convulsion			"Don't feel right"		
Amnesia			Difficulty concentrating		
Headache or pressure in the head			Difficulty remembering		
Neck pain			Fatigue or low energy		
Nausea or vomiting			Confusion		
Dizziness			Drowsiness		
Blurred vision			More Emotional		
Balance problems			Irritability		
Sensitivity to light			Sadness		
Sensitivity to noise			Nervous or anxious		

Memory Function (check whether they answered correctly or not)

Question:	Answered correctly	Answered Incorrectly
Where are we playing today?		
Which half is it?		
Who scored last in this game?		
What team did you play last game?		
Did your team win the last game?		

Concentration Test (check whether they answered correctly or not)

Question:	Answered correctly	Answered Incorrectly
Repeat the days of the week backwards, Start with Sunday		
Repeat this number backwards: 419		

Balance Test

Have athlete stand heel to toe with hands on hips and eyes closed. Count how many times they are out of the start position (hands off hips, opening eyes, lifting a heel, stepping, falling off balance, etc.) during 20 sec.

	Less than 5	More than 5
ERRORS		

When completed, a copy of this form must be given to your Athletic Director and the CYO Office by mail, fax, or email



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