

# MATCH DAY HEAD INJURY

## ASSESSMENT & REFERRAL FORM | AGES 12 & UNDER



### SIDELINE FORM (to be completed by the examiner (first aider/trainer) on the day of the suspected concussion)

<b>PLAYER NAME</b>	<b>CLUB</b>
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### DETAILS OF INCIDENT

**DATE**

**OCCURRED AT:**     **MATCH**         **TRAINING**         **OTHER**

**BRIEF DESCRIPTION**

#### IDENTIFICATION OF RED FLAGS (tick all those that apply)

Loss of consciousness	<input type="checkbox"/>
Seizure or convulsions	<input type="checkbox"/>
Deterioration of conscious state	<input type="checkbox"/>
Persistent or increasing vomiting	<input type="checkbox"/>
Double vision	<input type="checkbox"/>
Severe or increasing headache	<input type="checkbox"/>
Increasing restlessness, agitation, or combative behaviour	<input type="checkbox"/>
Neck pain	<input type="checkbox"/>
Weakness or tingling/burning in the arms or legs	<input type="checkbox"/>

**ACTION:** If any one of the boxes above is ticked, an ambulance should be called for immediate transportation to hospital.

#### FEATURES OF A SUSPECTED CONCUSSION (tick all those that apply)

Loss of responsiveness	<input type="checkbox"/>
Motor incoordination (losing balance, staggering, etc)	<input type="checkbox"/>
Confused/disorientation (not aware of plays or events)	<input type="checkbox"/>
Impaired memory (unable to recall events before or after the injury)	<input type="checkbox"/>
Looking/feeling dazed, blank or vacant	<input type="checkbox"/>
Player reporting symptoms:	
a. 'don't feel right'	<input type="checkbox"/>
b. more emotional than usual - sad, nervous or anxious	<input type="checkbox"/>
c. 'feel slowed down', confused or 'feel like in a fog'	<input type="checkbox"/>
d. Sensitivity to light or noise	<input type="checkbox"/>
The player is not their normal self, or there is any other concern that they are not quite right	<input type="checkbox"/>
Other (please list):	

**ACTION:** for any suspected concussion, the player needs to see a doctor as soon as practical for assessment, including confirmation of the diagnosis. The player must not return to play or full contact training until they have been cleared by a doctor.

<b>EXAMINER NAME</b>	<b>ROLE AT CLUB</b>
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<b>EXAMINER SIGNATURE</b>	<b>DATE</b>
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# MATCH DAY HEAD INJURY

## CHILD REPORT | AGES 12 & UNDER



### PLAYER FORM (to be completed on the day of the suspected concussion)

<b>PLAYER NAME</b>	
<b>CLUB</b>	<b>AGE</b>
How many concussions has your child had in the past?	
When was the most recent concussion?	
How long was the recovery (time to being cleared to play) for the most recent concussion? (approximate number of weeks)	

Ask the child to rate their symptoms based on how they are feeling now, with "1" representing the symptom is "a little" and "3" representing that the symptom is "a lot"

### SYMPTOM EVALUATION

	NOT AT ALL/NEVER 0	A LITTLE/RARELY 1	SOMEWHAT/SOMETIMES 2	A LOT/OFTEN 3
I have headaches				
I feel dizzy				
I feel like the room is spinning				
I feel like I'm going to faint				
Things are blurry when I look at them				
I see double				
I feel sick to my stomach				
I get tired a lot				
I get tired easily				
I have trouble paying attention				
I get distracted easily				
I have a hard time concentrating				
I have problems remembering what people tell me				
I have problems following directions				
I daydream too much				
I get confused				
I forget things				
I have problems finishing things				
I have trouble figuring things out				
It's hard for me to learn new things				
My neck hurts				

Do the symptoms get worse with physical activity?    **YES**    **NO**  
 Do the symptoms get worse with trying to think?    **YES**    **NO**

### OVERALL RATING FOR CHILD TO ANSWER

	VERY BAD									VERY GOOD
	1	2	3	4	5	6	7	8	9	10
On a scale of 0 to 100% (where 100% is normal), how would you rate the child now?										

If not 10, in what way do you feel different? .....

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# MATCH DAY HEAD INJURY

## PARENT OR GUARDIAN REPORT | AGES 12 & UNDER



### SYMPTOM EVALUATION

	NOT AT ALL/NEVER 0	A LITTLE/RARELY 1	SOMEWHAT/SOMETIMES 2	A LOT/OFTEN 3
has headaches				
feels dizzy				
has a feeling that the room is spinning				
feels faint				
has blurred vision				
has double vision				
experiences nausea				
gets tired a lot				
gets tired easily				
has trouble sustaining attention				
is distracted easily				
has difficulty concentrating				
has problems remembering what he/she is told				
has difficulty following directions				
tends to daydream				
gets confused				
is forgetful				
has difficulty completing tasks				
has poor problem-solving skills				
has problems learning				
has a sore neck				

Do the symptoms get worse with physical activity?  YES  NO

Do the symptoms get worse with trying to think?  YES  NO

### OVERALL RATING FOR PARENT/TEACHER/COACH/CARER TO ANSWER

On a scale of 0 to 100% (where 100% is normal), how would you rate the child now?

If not 100%, in what way does the child seem different? .....

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