This concussion supplement is a guideline to be used for athletes who answer YES to any questions between <u>9 - 14</u> on the PPE form (©2010, American Academy of Family Physicians, et al), or have a known history of concussion or indicators for further evaluation. (4/11/18)

NAME: DATE:

Previous Concussion or Concussion symptoms lasting more than one day	Type of symptoms (describe)	Severity of symptoms (0-6)	Duration of symp- toms (hours/days/weeks)	LOC/Amnesia (Y/N)	Convulsions/Seizures (Y/N)
Date:					
Date:					
All symptoms resolved (Y/N) If yes, list date If no, describe					
History of migraines or sleep disturbances? (Y/N) If yes, describe					
Ongoing difficulty w school/grades? (Y/N) If yes, describe					