Brendan Byrnes, AT,C, LAT
Certified Athletic Trainer
Passaic Valley High School

CONCUSSION HOME INSTRUCTIONS

Athlete _____ Date of Injury _____ Sport _____

Home Phone _____ Parent/Guardian Name _____

Your son/daughter has sustained a head injury while participating in _____. In some instances, the signs of a concussion do not become obvious until several hours or even days after the injury. Please be especially observant for the following sign and symptoms.

1. Headaches (especially one that increases in intensity*)
2. Nausea and vomiting*
3. Difference in pupil size from right to left eye, dilated pupils*
4. Mental confusion/behavior changes
5. Dizziness
6. Memory Loss
7. Ringing in the ears
8. Changes in gait (walking) or balance
9. Blurry or double vision*
10. Slurred speech*
11. Noticeable changes in the level of consciousness (difficulty awakening, or losing consciousness suddenly)*
12. Seizure activity*
13. Decreased or irregular pulse or respiration*
14. Sensitivity to light or noise

***Seek medical attention at the nearest emergency department.**

The best guideline is to note symptoms that worsen, and behaviors that seem to represent a change in your son/daughter. If you have any questions or concerns at all about the symptoms you are observing, contact you family physician for instructions, or seek medical attention at the closest emergency department. Otherwise, you can follow the instructions outlined below.

It is OK to:

- Use acetaminophen (Tylenol) for headaches
-Use ice pack on head & neck as needed for comfort
- Eat a light diet
- Go to sleep
- Rest (no strenuous activity or sports)

There is NO need to:

- Check the eyes with a flashlight
- Wake up every hour
- Test reflexes
- Stay in bed

Do NOT:

- Drink alcohol
- Drive while symptomatic
- Exercise or lift weights
- Take ibuprofen, aspirin, naproxen or other non-steroidal anti-inflammatory medications
- Play video games / watch excessive TV

Please remind your child to check in with the School Nurse prior to going to class, on the first day he or she returns to school. Your child should also follow up with the Certified Athletic Trainer after school.

Recommendations provided to _____ Phone _____

Recommendations provided by Brendan M. Byrnes, AT,C, LAT Phone 973-890-2537

Date _____ Time _____

Brendan M. Byrnes, ATC
Certified Athletic Trainer
Passaic Valley High School
973-890-2537

Post-Concussion Symptom Scale

Student Name: _____ **Sport:** _____ **Date of Injury:** _____ **Date for Day 1 is:** _____
Completed by: Brendan M. Byrnes, ATC

Mild = 1, Moderate = 2 or Severe = 3 for the symptoms that apply

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
Headache																					
Neck Pain																					
Nausea/Vomiting																					
Balance/Dizziness																					
Irritability																					
Fatigue																					
Sleep Changes																					
Diff. Reading/TV																					
Light Sensitivity																					
Noise Sensitivity																					
Visual Disturbance																					
“In a Fog” Feeling																					
Memory Difficulty																					
Concentration Diff.																					
Personality Change																					
School/Study																					
Ringing In Ears																					

Notes: