Attachment G

Parent Weekly Surveillance Report

Form Approved
OMB No: 0920-XXXX
Exp. Date:

Date __ __ / __ __ / __ __

Weekly survey: Parent

A. In the past week, has your child had any hits to his/her head or body that occurred during a soccer practice or game AND then developed any of the following symptoms?

	YES	NO
1. Headache		
2. “Pressure in head”		
3. Nausea or vomiting		
4. Dizziness		
5. Blurred vision		
6. Balance problems		
7. Sensitivity to light		
8. Sensitivity to noise		
9. Feeling slowed down		
10. Feeling like “in a fog”		
11. “Don’t feel right”		
12. Difficulty concentrating		
13. Difficulty remembering		
14. Fatigue or low energy		
15. Confusion		
16. Drowsiness		
17. Trouble falling asleep		

18. More emotional
19. Irritability
20. Sadness
21. Nervous or anxious
22. Loss of consciousness (passed out)
    i. How many minutes were you unconscious (passed out)? _____minutes

B. In how many games did your child see playing time this week?_____

C. How many soccer practices did your child participate in this week? _____