Mount Greylock Regional School
1781 Cold Spring Road
Williamstown, MA 01267
Tel: (413) 458-9582 Fax: (413) 458-9581

Dear Physician,

This patient is currently a student at Mount Greylock Regional School and is in need of medical attention or clearance for a head injury. In accordance with Massachusetts Law 105CMR 201.000, Mount Greylock has developed a policy that every student with a head injury or possible concussion must be evaluated and cleared by a physician before they are able to return to physical education and/or athletic participation.

The attached forms have been reviewed and revised. To facilitate the student's return to activities and to help the school ensure all needed accommodations are met, please complete the attached *Academic Recommendation Form* as soon as possible. Additionally, when the student is medically cleared to return to full physical participation, please complete the *Post Sports-Related Head Injury Medical Clearance and Authorization Form*. The first form stipulates what restrictions, if any should be placed upon the student's academic and physical activities. If you are placing restrictions on either activity, please provide a date by which the student will be re-evaluated. The second form states that the student is symptom free, has completed the state mandated Return-to-Play protocol, and is able to safely participate in physical education and athletics at Mount Greylock. **If there is no evidence of completion of the return to play protocol, students will be required to begin that upon return. The student will be out for a minimum of five days once the protocol has begun.** Students not enrolled in Physical Education or participating on an athletic team will be required to complete this protocol with the physician.

We appreciate your help with these forms so that we may comply with the Massachusetts Law and ensure our students are safe. Please feel free to contact me or the school nurse at the school if you have any questions. Thank you for your cooperation and willingness to help our students.

Sincerely,

Lindsey von Holtz
Director of Athletics and Co-Curricular Activities
Mount Greylock Regional School
1781 Cold Spring Road, Williamstown, MA 01267
(413) 458 - 9582 x103

ACADEMIC RECOMMENDATION FORM
PLEASE SEND THIS FORM BACK WITH STUDENT IMMEDIATELY

Patient Name:_____ Date of Birth: _____
Date of Evaluation: _____ Referred by: _____
Duration of Recommendations: 1 week 2 weeks 4 weeks Until further notice

The patient will be reassessed for revision of these recommendations in _____ weeks.

This patient has been diagnosed with a concussion (a brain injury) and is currently under our care. Flexibility and additional supports are needed during recovery. The following are suggestions for academic adjustments to be individualized for the student as deemed appropriate in the school setting.

Attendance
____ No school for ____ school day(s)
____ Attendance at school ____ days per week
____ Full school days as tolerated by student
____ Partial days as tolerated by the student

Visual Stimulus
____ Allow student to wear sunglasses/hat
____ Pre-printed notes (or note taker) for class
____ Limited computer/bright screen use
____ Reduce brightness on monitors/screens
____ Change classroom seating as necessary

Audible Stimulus
____ Lunch in a quiet place with a friend
____ Avoid music or shop classes
____ Allow to wear earplugs as needed
____ Allow class transitions before bell

Breaks
____ Allow the student to go to the nurse's office if symptoms increase
____ Allow student to go home if symptoms do not subside
____ Allow breaks during the school day as deemed necessary by school nurse

Workload/Multi-Tasking
____ Reduce overall amount of make-up work, classwork and homework *(Approx %: ___)*
____ Reduce amount of work given each night to approximately ____ minutes per class.
____ Allow _____ for make-up work

Testing
____ Additional time to complete tests
____ No more than one test a day
____ No standardized testing until _____
____ Allow for scribe, oral response, and oral delivery of questions, if available

Physical Exertion
____ No physical exertion/athletics/PE
____ Walking in PE class or athletic practice only
____ Begin graduated return to play protocol
(This is only possible for students currently enrolled in PE or participating in athletics)

Additional Recommendation
_____
_____
_____

Current Symptom List (the student is noting these today)

____ Headache	____ Visual problems	____ Sensitivity to noise	____ Memory issues
____ Nausea	____ Balance problems	____ Feeling foggy	____ Fatigue
____ Dizziness	____ Sensitivity to light	____ Difficulty concentrating	____ Irritability

Student is reporting more difficulty with/in

____ All subjects	____ Science/Math	____ Foreign Language	____ Reading
____ Music	____ Using Computers	____ Focusing	____ Listening

____ Other: _____

I, _____ give permission for Dr. _____ to share the following information with my child's school and for communication to occur between the doctor and the school for changes to this plan.

_____
Parent Signature Date

Revised 6/19/17

Mount Greylock Regional School & MA Department of Public Health

POST SPORTS-RELATED HEAD INJURY MEDICAL CLEARANCE AND AUTHORIZATION FORM

Student's Name	Sex	Date of Birth	Grade

Date of injury: _____ Nature and extent of injury: _____

Symptoms following injury (check all that apply):

☐ Nausea or vomiting	☐ Headaches	☐ Light/noise sensitivity
☐ Dizziness/balance problems	☐ Double/blurry vision	☐ Fatigue
☐ Feeling sluggish/"in a fog"	☐ Change in sleep patterns	☐ Memory problems
☐ Difficulty concentrating	☐ Irritability/emotional ups and downs	☐ Sad or withdrawn

Duration of Symptom(s): _____ Diagnosis: □ Concussion □ Other: _____

The student must be completely symptom free at rest, during exertion, and with cognitive activity prior to returning to full participation in extracurricular athletic activities.

The student will not be cleared if the Return to Play information below is not complete.
If concussion diagnosed, date student completed graduated return to play plan without recurrent symptoms: _____

- *Students not involved in an interscholastic athletic program or not currently enrolled in PE must complete the Return to Play Protocol with the physician.*
- *Students involved in one of those programs will be required to complete the attached RTP protocol if no date is listed above.*

Prior concussions (number, approximate dates): _____

I HEREBY AUTHORIZE THE ABOVE NAMED STUDENT FOR RETURN TO ATHLETIC ACTIVITY

Practitioner signature: _____ Date: _____

Print Name: _____

□ Physician □ Licensed Athletic Trainer □ Nurse Practitioner □ Neuropsychologist □ Physician Assistant

License Number: _____

Address: _____ Phone number: _____

I ATTEST THAT I HAVE RECEIVED CLINICAL TRAINING IN POST-TRAUMATIC HEAD INJURY ASSESSMENT AND MANAGEMENT APPROVED BY THE DEPARTMENT OF PUBLIC HEALTH* OR HAVE RECEIVED EQUIVALENT TRAINING AS PART OF MY LICENSURE OR CONTINUING EDUCATION.

Practitioner's initials: _____ * MDPH approved Clinical Training options can be found at: www.mass.gov/dph/sports concussion

Type of Training: ☐ CDC on-line Clinician Training
☐ Other MDPH approved Clinical Training
☐ Other (Describe)_____

****This form is not complete without the practitioner's verification of such training.

Revised 6/19/17

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GRADUATED RETURN TO PLAY PROTOCOL

Once a student is symptom free at rest for 24 hours and has a signed release by the treating clinician, he/she may begin the return-to-play progression below. Each step will take at least 24 hours, so will take a student at minimum one week to proceed through the full rehabilitation protocol. The steps below can begin only when the student has been symptom free after a full day of normal cognitive activities.

Name: _____ **Grade: _____**

If at any point, symptoms return, the student will drop back to the previous asymptomatic level and try to progress again after an additional 24-hour period of rest has passed. The nurse will notify the PE Teachers and Athletic Director if any symptoms are reported.

Step 1: Light Aerobic Activity/Exercise

This includes walking, swimming, or stationary cycling. No resistance training.
Keep the intensity < 70% maximum percentage heart rate for approximately 15 minutes.
The objective of this step is increased heart rate.

Begin Date: _____, _____ **Student can begin Step 2: _____, _____**
PE Teacher/Coach Date Initial *Nurse Signature Date Cleared*

Step 2: Sport Specific Activity/Exercise

This includes skating and/or running. No chance of head impact or equipment (incl. balls) allowed.
Heart rate should remain < 80% for approximately 45 minutes.
The objective of this step is to add movement and continue to increase heart rate.

Begin Date: _____, _____ **Student can begin Step 3: _____, _____**
PE Teacher/Coach Date Initial *Nurse Signature Date Cleared*

Step 3: Non-contact Training Drills (Skill Drills)

Progress to more complex training drills (passing, shooting, serving, etc.) in a controlled environment.
The student may initiate progressive resistance training.
Heart rate should remain < 90% for approximately 60 minutes.
The objective of this step is to increase exercise, coordination and attention.

Begin Date: _____, _____ **Student can begin Step 4: _____, _____**
PE Teacher/Coach Date Initial *Nurse Signature Date Cleared*

Step 4: Full Contact Practice

This includes participation in normal training activities. Student may participate in full practice, including small sided scrimmages (1v1, 3v2, etc.) and inter-squad scrimmages.
The objective of this step is to restore confidence and to assess functional skills.

Begin Date: _____, _____ **Student can Return to Play: _____, _____**
PE Teacher/Coach Date Initial *Nurse Signature Date Cleared*

Step 5: Return to Play

Return to play involving normal exertion or game activity.
If the student athlete exhibits a re-emergence of any concussion signs or symptoms once they return to physical activity, the student should be removed from further activities and return for re-evaluation.

Students need to bring this form to the nurse prior to beginning each step. Students should bring this form to PE/Practice throughout the process. The PE Teacher/Coach will not allow student to begin a step without release from the Nurse. The PE Teacher/Coach should enter the date and initial each step to indicate the step has begun. Once student have been cleared to return to play, the nurse will keep the form and notify the PE Teachers and Athletic Director.