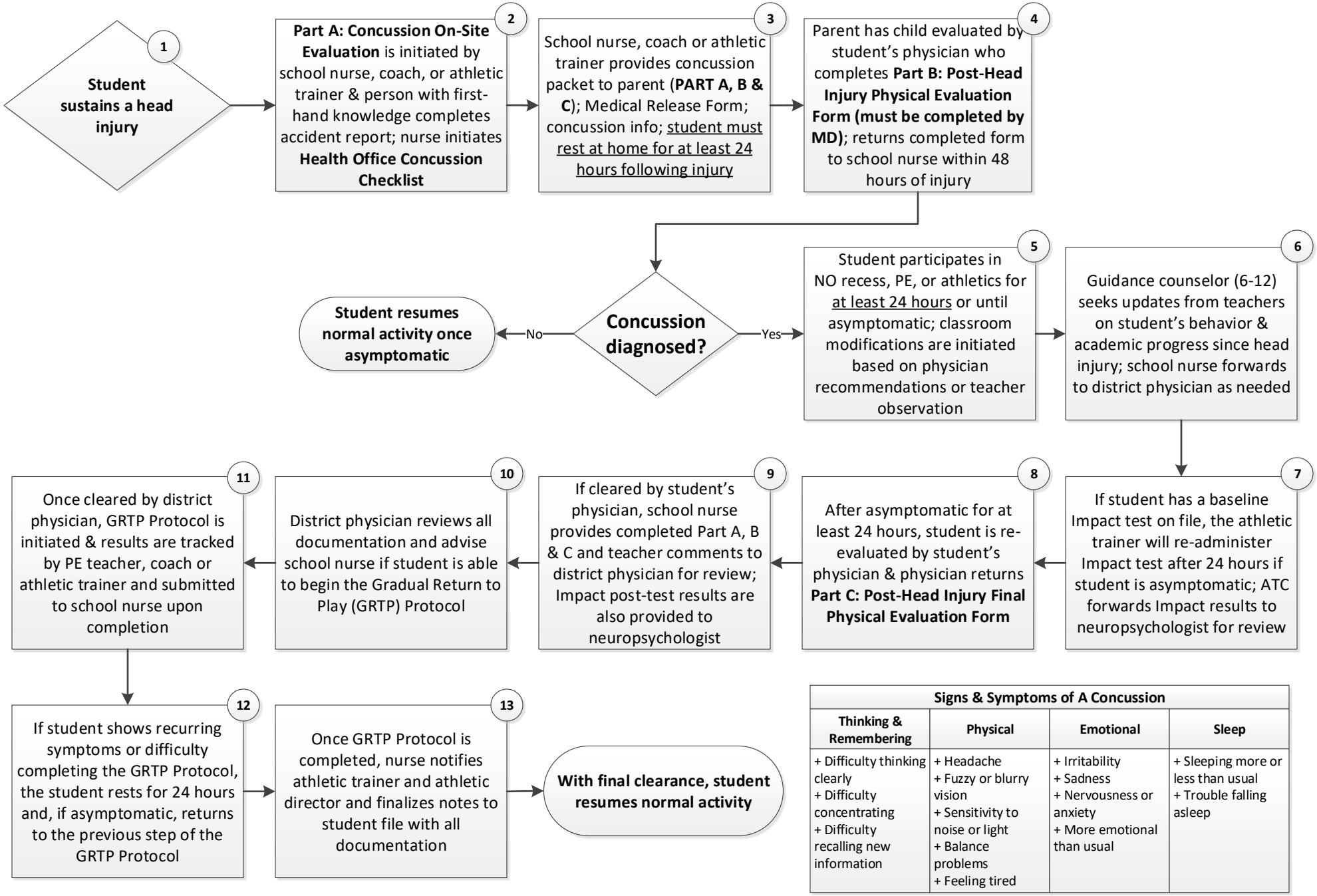
Harrison Central School District
Concussion Management Protocol for Student Athletes



Signs & Symptoms of A Concussion			
Thinking & Remembering	**Physical**	**Emotional**	**Sleep**
+ Difficulty thinking clearly + Difficulty concentrating + Difficulty recalling new information	+ Headache + Fuzzy or blurry vision + Sensitivity to noise or light + Balance problems + Feeling tired	+ Irritability + Sadness + Nervousness or anxiety + More emotional than usual	+ Sleeping more or less than usual + Trouble falling asleep

11/10/22

HARRISON CENTRAL SCHOOL DISTRICT

50 Union Avenue, Harrison, NY 10528

Concussion Management Protocol

Student Athletes

Recognition of a Concussion

1. Coaches/Athletic Trainer/Nurse/Teachers/Students/Parents/Guardians are responsible for knowing signs and symptoms of a concussion and **reporting to the school nurse** if they suspect that a student has sustained a concussion.
2. If the concussion is suspected in a Harrison CSD Student Athlete **Part A of the concussion packet**, an initial evaluation, must be filled out. Part A can be filled out by school nurse, PE teacher, Coach, or Athletic Trainer. **Part A must be submitted to the nurse.** In addition to Part A being filled out, an accident report must be completed and submitted to the Director of Physical Education, Health & Athletics. The school nurse will initiate the Health Office Concussion Checklist.
3. **The school nurse, coach or athletic trainer provides the concussion packet to parent.** Packet will include: Permission to release information; Part A, Part B, Part C; and CDC fact sheet with information on concussions. **Note: The medical release needs to be filled out by the parent/guardian. Part B & C must be completed, signed and stamped by a Medical Doctor (as specified on each form). The forms are returned to the school nurse and forwarded to the District Physician.**

Once a Concussion is Diagnosed

1. Once the school nurse receives a confirmed diagnosis from the student's physician (Part B), the school nurse notifies the guidance counselor, who in turn notifies teachers, that that students may not attend school or participate in any physical activity for a minimum of 24 hours and must be asymptomatic for at least 24 hours before returning to school. Class modifications are initiated based on physician's recommendations or teacher observation. These modifications are coordinated by the guidance counselor.
2. If classroom accommodations are needed based on recommendations given by the primary care physician, then the guidance counselor will be responsible for overseeing a student's academic program. This will be on a case-by-case basis. Examples of restrictions may include, but are not limited to: extra time for homework and tests, school attendance limited to 2 hours per day, etc.
3. Guidance counselor seeks updates from teachers on student's behavior & academic progress since the head injury; school nurse forwards these notes to district physician as needed. Teachers must report any changes in behavior or classroom performance to either guidance counselor or directly to school nurse. Coordination among the nurse, guidance counselor, school psychologist, teachers, and school administrators may be necessary to monitor the management/progression of the student's classroom performance.
4. The Certified Athletic Trainer may have student retake Impact Test at least 24 hours and asymptomatic after injury.
    a. Certified Athlete Trainer is responsible for contacting the district's neuropsychologist to review all Impact tests if indicated. Recommendations by the neuropsychologist, based on test results, will then be shared with the school nurse and the district's physician.
    b. If athlete does not meet his/her baseline numbers they may be retested.
5. **All student athletes who have been diagnosed with a concussion will be required to rest for a minimum of 24 hours and must be asymptomatic with Part C completed before they can be considered for Gradual Return to Play Protocol.**

6. Part C is a second evaluation that must be completed by the students' primary care physician. Part C must be signed and stamped by the physician in order for it to be accepted by the school nurse. Part C may need to be filled out multiple times based on the duration of the student's symptoms.
7. In order for a student to be considered eligible to begin Gradual Return to Play, the school nurse must provide the district physician with the following:
    a. A copy the completed Part A, Part B, and Part C.
    b. Impact clearance from the neuropsychologist, if indicated.
    c. Most recent follow up E-mail from guidance counselor and/or teacher.

Return to Play or Activity

1. Once the nurse has obtained medical clearance by the school physician, the student may begin the Gradual Return to Play (GRTP) Protocol.
    a. GRTP Protocol will be conducted by either the student's Physical Education Teacher or Certified Athletic Trainer.
    b. Students must complete the GRTP protocol each day with no recurring or worsening sign/symptoms of a concussion in order to progress to the next day's activities, and there must be at least 24 hours between each step of the GRTP protocol.
    c. If the student has recurring signs and symptoms of a concussion, the student must stop all activity, and wait until he/she has been completely asymptomatic for at least 24 hours before returning to the GRTP Protocol. When students resume the GRTP Protocol, they must do so at the step immediately prior to their last attempt. For example, if the student becomes symptomatic on Day 3 of the GRTP Protocol, then after 24 hours of being asymptomatic the student will start on Day 2's activity and progress from there.
2. **Progress of the student's GRTP Protocol must be recorded on the Return to Play Form and submitted to the school nurse once completed.**
3. Once the GRTP Protocol has been completed and submitted to the school nurse, the nurse will forward the GRTP Protocol to the Certified Athletic Trainer or Director of Physical Education, Health & Athletics for final review. The nurse will file all documentation in the student's medical file.
4. Once the final medical clearance is given to the school nurse, the school nurse will notify the student's parents, guidance counselor and/or teachers that the student has been medically cleared of his/her concussion. If the student had any restrictions, they will be lifted unless noted otherwise.

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Concussion Management Protocol

STUDENT ATHLETE
SECONDARY LEVEL (6-12) HEALTH OFFICE CONCUSSION CHECKLIST

Student:_____ Grade:_____ Date:_____

Date of Injury:_____ Notified By:_____

PE Teacher:_____ Guidance Counselor:_____

Date Completed:

_____ Part A is filled out and given to Nurse

_____ Incident report if injury occurred on school property

_____ Concussion packet provided to parent

_____ Remove from PE and physical activity

_____Signed parental consent received

ATHLETES ONLY: In addition to Checklist on the Left

_____ IMPACT Testing seven (7) days after injury or until asymptomatic

_____ Cleared by Neuropsychologist to begin GRTP

_____ District Physician Clearance

_____ GRTP to begin after MD review

_____ E-mail guidance counselor and principal/AP alerting of concussion or head Injury

_____Check medical chart for previous concussions: List Concussion Hx dates:_____

_____Received Signed and Stamped Part B from student's physician

_____ If medical note necessary for school attendance, advise guidance counselor and principal/AP of academic modifications

_____ Completed Part C returned by physician

_____ Check with guidance counselor for academic progress note for Return to Learning

_____ E-mail School MD copy of completed Form A, Form B, Form C, and academic progress note

_____ "District Physician Evaluation" form completed by School MD & returned to nurse

_____Notify guidance counselor and PE teacher of GRTP*

_____Secure final clearance that GRTP has been completed from Athletic Trainer

_____Notify parents of completed GRTP/Clearance

*If student has difficulty completing GRTP, district physician should be consulted

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Concussion Management Protocol

Return to Play/Activity Progression-Secondary (6-12) Levels

Level 1: Low levels of physical activity

- The Goal: only to increase a student's heart rate.
- The Time: 5 to 10 minutes.
- The Activities: walking at a brisk pace around the track once or the gym a few times. Check in with student; if student continues to be asymptomatic for 24 hours then advance to Level 2.

Level 2: Moderate levels of physical activity

- The Goal: limited body and head movement.
- The Time: Reduced from typical routine-Time 15-20 minutes
- The Activities: This includes jogging, brief running, stationary biking, weightlifting walk/jog moderately for 10 minutes and complete 20 jumping jacks. Check in with student to make sure he/she is symptom free. If student continues to be symptom free for 24 hours then advance to Level 3.

Level 3: Heavy Non-contact physical activity

- The Goal: more intense but non-contact
- The Time: Close to Typical Routine 30-40 minutes
- The Activities: This includes sprinting, running, high intensity biking, weightlifting.
- Check in with student to make sure he/she is symptom free. If student continues to be symptom free for 24 hours then advance to Level 4

Level 4: Non- Contact training/ skill drills /limited participation in PE

- The Goal: Sustaining elevated heart rate for a period of time.
- The Time: 20-25 minutes
- The Activities: Circuit drills: a mixture of agility, speed, and strengthening drills. Examples include: sit ups, mountain climbers, knee bends, jumping jacks, partner work. Check in with student to make sure he/she is symptom free for 24 hours then advance to Level 5

Level 5: Full-contact controlled practice/limited participation in PE

- The Goal: more intense than non-contact
- The Time: Class period
- The Activities: same as non-contact activities but must include change of planes. This can also be tailored to class curriculum so it's sport/activity specific. Check in with student to make sure he/she is symptom free for 24 hours then advance to Level 6.

Level 6: Full-contact in game play/full participation in PE

- The Goal: more intense full-contact
- The Time: Class period
- The Activities: Participation in regular activity during physical education class. Check in with student to make sure they are symptom free. If student continues to be symptom free for 24 hours then he/she should be reinstated to full participation in Physical Education class and recess.

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Concussion Management Protocol

Inform student: "If any of these symptoms are present at any time during the school day let your teacher know and go to the nurse." After the GRTP (Gradual Return to Play) is finished the Athletic Trainer or the PE teacher must send the nurse a completed Return to Play Protocol form on the student. This information will be included in the student's health folder.

Return to Play/Activity Protocol Form-- Secondary (6-12) Level

Level	Exercise	Date	Completed/Comments	Teacher Name
1	**Low levels** of physical activity. This includes walking, light jogging, light biking, light weight lifting. Time:5-10 minutes			
2	Activity: **Moderate levels** of physical activity with body/head movement. This includes jogging, brief running, stationary biking, weightlifting. Time: 15-20 minutes			
3	Activity: **Heavy non-contact** physical activity. This includes sprinting, running, high intensity biking, weightlifting. Time 25-35 minutes			
4	Activity**: Non-Contact Skill Drills** such as Circuit drills. Examples include: sit ups, mountain climbers, knee bends, jumping jacks Time: 20-30 minutes			
5	Activity: **Full contact** in controlled practice-same as above but have student working with other classmates. Time: Full period			
6	**Full contact** in game play. Participation in regular activity during physical education class. Time: Full class period.			

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Concussion Management Protocol

Student Athlete Concussion Evaluation Checklist On Site Evaluation Form

Completed by Coach, Athletic Trainer, Nurse or Athletic Director at Time of Injury or Within 24 Hours

PART A

Student Name: _____ Age: _____ Grade: _____ D.O.B. _____

Activity/Sport: _____ Date of Injury: _____ Time: _____ Location: _____

Description of injury and how it occurred: _____

Was there a loss of consciousness?	☐ Yes	☐ No	☐ Unclear
Does he/she remember the injury?	☐ Yes	☐ No	☐ Unclear
Did he/she have confusion after the injury?	☐ Yes	☐ No	☐ Unclear

SYMPTOMS OBSERVED AT TIME OF INJURY: (Please Circle)

Amnesia	Yes	No	Blurred vision	Yes	No	Glassy eyed	Yes	No
Confusion	Yes	No	Light sensitivity	Yes	No	Fatigue or low energy	Yes	No
Headache	Yes	No	Sound sensitivity	Yes	No	Memory problems	Yes	No
Balance Issues	Yes	No	Nausea or vomiting	Yes	No	Ringing in ears	Yes	No
Dizziness	Yes	No	Drowsy/Sleepy	Yes	No	Slowed reaction	Yes	No
Seizure	Yes	No	Loss of orientation	Yes	No	Vacant stare	Yes	No

Other findings/comments: _____

Actions Taken:

- ☐ Parents notified*
- ☐ Health office notified*
- ☐ Ambulance called
- ☐ Taken to doctor by parent*
- ☐ Incident Report completed*
- ☐ Sent to hospital

*=required actions

Person Completing this form (print name): _____

Signature: _____ Title: _____

Address: _____

Phone: _____ Date: _____

HHS Health Office Fax: (914) 630-3346
Harrison Ave Main Office Fax: (914)835-4311
Parsons Main Office Fax: (914)835-4657

LMK Health Office Fax: (914) 630-3324
Purchase Main Office Fax: (914)946-0286
S.J. Preston Main Office Fax: (914)761-7166

HARRISON CENTRAL SCHOOL DISTRICT

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Concussion Management Protocol

Student Athlete Post-Head Injury – Physician Evaluation

PART B

*****Per NYS Law evaluations of student athletes must be completed and signed by an M.D.*****

Student Name:_____ D.O.B._____ Activity/Sport:_____

Date of Injury:_____ Mechanism of Injury:_____

Date of Evaluation:_____ Time of Evaluation: _____

SYMPTOMS CURRENTLY REPORTED/OBSERVED (Please Circle)

Amnesia	Yes	No	Blurred vision	Yes	No	Glassy eyed	Yes	No
Confusion	Yes	No	Light sensitivity	Yes	No	Fatigue or low energy	Yes	No
Headache	Yes	No	Sound sensitivity	Yes	No	Memory problems	Yes	No
Balance Issues	Yes	No	Nausea or vomiting	Yes	No	Ringing in ears	Yes	No
Dizziness	Yes	No	Drowsy/Sleepy	Yes	No	Slowed reaction	Yes	No
Seizure	Yes	No	Loss of orientation	Yes	No	Vacant stare	Yes	No

Other findings/comments:_____

_____

Prior Medical History/Risk Factors (ex: ADD, Meds, LD, SZ, Migraines, previous concussions):_____

_____

Concussion Diagnosis? ☐ **Yes** ☐ **No**

If the student is diagnosed with a concussion, he/she must stay home and rest for at least 24 hours from the time of the injury.

Is the student able to return to school after 24 hours of rest? ☐ **Yes** ☐ **No**

List any learning/activity accommodations or restrictions required at school (e.g., reduced schedule, limit screen time, etc.)

_____

_____

_____

_____

A student diagnosed with a concussion must be asymptomatic for at least 24 hours and re-evaluated by a MD. At the second evaluation, the physician must complete **PART C.** ***Final clearance to return to sports must be determined by the Harrison Central School District's Physician.***

Print Name:_____ Date:_____

Physician's Signature:_____ ****MD STAMP REQUIRED****

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Concussion Management Protocol

Student Athlete Post-Head Injury – Final Physician Evaluation

PART C

Student Name: _____ D.O.B._____ Activity/Sport:_____

Grade:_____Date of Injury:_____ Time: _____

Date of Evaluation:_____ Time of Evaluation:_____

FINAL EVALUATION: (MUST BE COMPLETED BEFORE RETURN TO P.E./PLAY/PRACTICE/GAME)

Amnesia	Yes	No	Blurred vision	Yes	No	Glassy eyed	Yes	No
Confusion	Yes	No	Light sensitivity	Yes	No	Fatigue or low energy	Yes	No
Headache	Yes	No	Sound sensitivity	Yes	No	Memory problems	Yes	No
Balance Issues	Yes	No	Nausea or vomiting	Yes	No	Ringing in ears	Yes	No
Dizziness	Yes	No	Drowsy/Sleepy	Yes	No	Slowed reaction	Yes	No
Seizure	Yes	No	Loss of orientation	Yes	No	Vacant stare	Yes	No

Other findings/comments:_____

_____

Prior Medical History/Risk Factors (ex: ADD, Meds, LD, SZ, Migraines, previous concussions):_____

_____

List any physical or learning accommodations/restrictions: _____

_____

_____

_____

Is the student/athlete ready to return to participate in the **Gradual Return to Play Protocol**? ☐ **Yes** ☐ **No**

If no, please list next follow-up date:_____

All students will participate in the Gradual Return to Play when approved by the School District Physician.

Physician's Name(Print):_____ Date: _____

Physician Signature: _____ ****MD STAMP REQUIRED****

****FINAL DETERMINATION AND RETURN TO PLAY BY SCHOOL PHYSICIAN ONLY****

HARRISON CENTRAL SCHOOL DISTRICT

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Concussion Management Protocol

Standard E-Mail to Send To Teachers When Student Diagnosed With a Concussion

From: School Nurse
To: Classroom Teachers
RE: Student Name

The above student has been diagnosed with a concussion on_____. Along with being restricted from PE/Sports/Physical Activities, students with concussions can experience cognitive symptoms which can affect classroom performance. Some of these symptoms can include difficulty focusing, change in academic performance, such as scoring lower than normal for that student on tests & quizzes or not being able to "keep up" academically.

Please notify the Health Office should this student complain of not feeling well. Students with concussions can experience symptoms such as headache, nausea, difficulty concentrating, fatigue, etc.

Thank you,
School Nurse

[Be sure to CC the Supervisor of Guidance, Principal, and School Nurse]

EMAIL FOR GUIDANCE COUNSELOR (GRADES 6-12) TO SEND TO TEACHERS TO OBTAIN FEEDBACK ON ACADEMIC PROGRESS BEFORE STUDENT IS MEDICALLY CLEARED TO RETURN TO PLAY/ACTIVITY:

To Guidance Counselor:

Please advise if this student is receiving services (504, IEP, other). Please forward this email to the above student's teachers to obtain feedback on student's academic status.

E-mail:

The above student was diagnosed with a concussion on _____. Along with being restricted from PE/Sports/Physical Activities, students with concussions can experience cognitive symptoms which can affect classroom performance. Some of these symptoms can include difficulty focusing, change in academic performance, such as scoring lower than normal for that student on tests & quizzes or not being able to "keep up" academically.

Please respond ASAP to the following questions about this student's academic status:

1) Have you noticed any changes in the student's academic performance since the above date of concussion? For example, has this student's grades dropped? Is he/she having difficulty keeping up with class work, homework, etc.?
2) Has this student demonstrated any change in behavior? Any other concerns?

Thank you,
Guidance Counselor

[Be sure to CC the Supervisor of Guidance, Principal, and School Nurse]

HARRISON CENTRAL SCHOOL DISTRICT

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Concussion Management Protocol

Parental Consent to Release Medical Information

Student: _____ Date of Birth: _____ Date: _____

School: ☐ Parsons ☐ S. J. Preston ☐ Purchase ☐ Harrison Avenue

☐ Louis M. Klein Middle School ☐ Harrison High School

Student's Physician/practitioner: _____

Physician/practiioner Address (street,city/town, state, zipcode):

_____ Phone Number: _____

_____

To: Physician / Practitioner,

Please release any medical information on the above named patient to the school nurse in patient's respective school, and/or the district physician as requested.

_____ _____

Parent/Guardian Signature Date

Parent Signature Denotes Permission to Share Information With Staff on a Need-To-Know-Basis.

Return completed Parental Consent Form to your child's school nurse.

HARRISON CENTRAL SCHOOL DISTRICT

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Concussion Management Protocol

District Physician Evaluation

Student Name:_____ Age:_____ Grade:_____

Dear Parent/Guardian: "Repeated mild Traumatic brain injuries (TBIs) occurring over an extended period of time (i.e. months, years) can result in cumulative neurological and cognitive deficits. Repeated mild TBIs occurring within a short period of time (i.e. hours, days, or weeks) can be catastrophic or fatal" (see CDC Information on Traumatic Brain Injury). https://www.cdc.gov/traumaticbraininjury/get_the_facts.html

If indicated below, it is my recommendation that your child be evaluated by an expert in concussion evaluation and management. This is for the protection of your child and in order to make a wise determination of when it is relatively safe for him/her to return to play and how quickly he/she can resume full play in physical education and sports activities.

Management of Clearance to Return to Play

Student/athlete may participate in the Gradual Return to Play Protocol to resume sports/practice/games/PE when approved by the Health Office based on the following guidelines:

a. First/Any Concussion:
    i. Under no circumstances can a student/athlete who sustained a concussion participate in school sports/practices/games/PE for a minimum of seven (7) days following a concussive episode.
    ii. Completion of Physician Evaluation Form- Part C
b. Second or Multiple Concussion:
    i. Completion of Physician Evaluation Form- Part C
    ii. Will be evaluated on **a case-by-case basis** and may require more advanced testing.

First reported concussive episode:_____

Second reported concussive episode:_____

Third reported concussive episode: _____

☐ Cleared for full participation in sports

☐ Cleared for Gradual Return to Play

☐ Needs further evaluation

_____ _____

Signature of School District Physician Date

Scan copy of completed form to the School Health Office