

Return to Learn after a Concussion Protocol

A concussion is a type of mild traumatic brain injury, or TBI, caused by a bump, blow or jolt to the head that may not involve physical contact. Concussions can occur with or without a loss of consciousness. Only 10 percent of concussions involve a loss of consciousness! Signs and symptoms of a concussion can show up right after an injury, or may not appear for hours or even days after the injury.

I. Plan for the removal of a student from physical and mental activity when there is suspicion of a concussion:

- a. Any Endeavor Charter School (“ECS”) employee, coach, or volunteer who has reason to believe that a student has suffered from a concussion, is exhibiting concussion symptoms, or has otherwise been seriously injured, will immediately call 911. Symptoms requiring an immediate 911 call include, but are not limited to:
 - Change in consciousness
 - Severe pain or pressure in the head, neck or back
 - Tingling or loss of sensation in the hands, fingers, feet or toes
 - Partial or complete loss of movement of any body part
 - Unusual bumps or depressions on the head or over the spine
 - Blood or other fluids in the ears or nose
 - Heavy external bleeding of the head, neck or back
 - Seizures
 - Impaired breathing because of injury
 - Impaired vision (eg. double vision) because of injury
 - Nausea or vomiting
 - Persistent headache
 - Loss of balance
 - Bruising of the head, especially around the eyes or behind the ears

II. Notification Procedure:

- a. After immediate care is provided and/or 911 has been called, the ECS School Nurse, a staff member, or coach with information about the injury will contact the person(s) listed as the student’s emergency contact to convey the information. ECS staff will continue to call all available emergency contact numbers until someone is reached, leaving a voice message at every number possible. The ECS staff member will focus on providing the most significant information first, in a calm and clear manner.
- b. A follow-up email will be written and sent by the ECS staff member most qualified to report the circumstances of the incident. This email will be sent to the student’s emergency contacts and all individuals involved in the student’s education or extracurricular activities at ECS, as determined by the ECS Director or assignee (“Stakeholders”).
- c. ECS Stakeholders will be notified by email of any off campus or out of school concussion issues that may affect a student’s ECS activities.

III. Medical Care Plan/School Accommodations:

- a. ECS Stakeholders will follow all recommendations provided by the student’s doctor without question for concussions or other injuries which have occurred on campus or off campus. The school will encourage the family to share the ECS Return to Learn : Academic Accommodation Plan Following a Concussion

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form (attached and may be amended) with their doctor to have completed and returned to ECS. In place of this form, the school will follow an alternative plan provided by the doctor.

- b. If any decision is in question, or alternative care provisions provided, the school will choose the most cautious plan.

IV. Delineation of Return to Learn or Play Requirements:

- a. Unless otherwise dictated by the student’s doctor:
 - i. The student may not return to class or play on the day of injury.
 - ii. The student may not return to class or play while showing any symptoms of concussion.
 - iii. ECS Stakeholders will follow all recommendations provided by the student’s doctor without question.
 - iv. If a decision is in question, the school will choose the most cautious plan.
- b. The ECS School Nurse will delineate all medical information to the necessary Stakeholders. If any staff member receives additional information, this information will be immediately shared with the School Nurse who will confirm the information with the family and then share it with the Stakeholders.

ECS Stakeholders will be aware of the following symptoms of concussion injury:

Physical:	Sensory:	Emotional:	Cognitive:
<ul style="list-style-type: none"> ● Headaches ● Balance issues ● Fatigue ● Dizziness ● Difficulty sleeping ● Numbness/tingling 	<ul style="list-style-type: none"> ● Blurred vision ● Sensitivity to light or sound 	<ul style="list-style-type: none"> ● Sad ● Angry ● Worried ● Irritable ● Nervousness 	<ul style="list-style-type: none"> ● Brain “fog” ● Difficulty with memory ● Difficulty remaining focused

Endeavor Charter School Return to Learn: Academic Accommodation Plan Following Concussion

(To be completed by a medical provider)

This form should be brought to the ECS School Nurse immediately upon return to school to initiate the health alert process.

Student's name: _____ Date of birth: _____

The above named student has been diagnosed with a concussion (also known as a mild traumatic brain injury). Following a concussion, individuals need both cognitive and physical rest for the best and quickest recovery. Therefore it is important to limit activities that require a lot of thinking or concentration, as this can make symptoms worse.

The student is able to return to school on (date) _____ with the following recommended supports:

_____ No supports necessary. The student has been released to return to full academic and athletic/physical activities.

To promote cognitive rest:

_____ Allow for shortened school days. Recommend _____ hours per day until re-evaluated.

(Alternating days of morning and afternoon classes is suggested if \leq 4 hours per day recommended)

_____ Allow for shortened classes (ie. rest breaks during class) Maximum class length is _____ minutes/per class.

_____ Allow extra time for student to complete coursework/assignments.

_____ No classroom or standardized testing at this time, as this does not reflect the student's true abilities.

_____ Limited classroom testing permitted. No more than _____ questions and/or _____ total time.

_____ Student is able to take quizzes or tests that are written (no bubble sheets).

_____ Student is able to take tests but should be allowed extra time to complete.

_____ Lessen screen time (computer, videos, smartboard) to a maximum of _____ minutes per class AND no more than _____ continuous minutes (with 5-10 minute breaks in between).

_____ Print class notes and online assignments (14pt font recommended).

_____ Lessen homework by _____% per class; or to a maximum of _____ total minutes nightly for all classes, no more than _____ continuous minutes.

To address sensitivity to light and noise:

_____ Provide alternative setting during band or music class (outside of band/music classrooms).

_____ Provide alternative setting during recess to avoid noise exposure and risk of further injury (off playground).

_____ Allow early class release for class transitions to reduce exposure to hallway noise.

_____ Provide alternative location to eat lunch outside of the classroom.

_____ Allow the use of earplugs when in a noisy environment during the school day.

_____ Allow student to wear sunglasses or a hat with a bill worn forward to reduce light exposure.

To reduce the risk of further injury:

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- **Students participating on school athletic teams will be working with the Athletic Director, their athletic coaches, and medical providers on their gradual return to play and completion of the Gfellar-Waller form (attached).**
- **No student should return to full physical activity (team sports, recess, etc.) if ANY symptoms are present.**
- **For non-athletes in elementary or middle school:**

_____ No recess/participation in any classes or events involving sports/physical activity until re-evaluated.

_____ Patient has completed a return to play progression and is able to participate in recess and any other classes or events involving physical activity as long as symptom free.

_____ Can return to recess after completing a return to play progression under the supervision of the teacher as follows below. Student may progress to the next day ONLY if they do not experience any symptoms. If symptoms occur, rest one day and return to the last day activity with no symptoms. If they must “re-start” twice, consult the healthcare provider.

ONCE THE RETURN TO ACTIVITY FORM (attached) IS COMPLETED ALL ACADEMIC AND PHYSICAL RESTRICTIONS AND MODIFICATIONS ARE DISCONTINUED.

Day	Activity	Comments	Supervised by
1	20-30 minutes of cardio activity (ie. walking) No ball activities. Very light activity - not breathing hard. Check with students every 20 minutes during activity. STOP if symptoms.		
2	30 minutes of cardio; jogging, medium pace. Could do sit-ups, push-ups. Light lifting. No contact. Can shoot/dribble a basketball if alone. Intensity: breathing heavier, still able to talk while exercising. Check with student every 20 minutes during activity. STOP if symptoms.		
3	30 minutes of cardio; faster paced jogging. Sit-ups, push-ups, change of direction drills (shuttle run). Moderate lifting, no maxing. Intensity: Difficult for conversation. Check with student every 20 minutes.		
4	Warm up, able to run without restriction. Able to participate in sports, non-contact. Resume regular lifting. Check with student every 20 minutes.		
5	Able to return to all activities. Check with student every 20 minutes during activity to assure no return in symptoms. If symptoms occur, STOP and see school nurse.		

These recommendations are based on today's evaluation. Date: _____

Student is scheduled to return to this office (Date or number of weeks): _____

Referral made to: Sports Medicine _____ Neurology _____ Psychiatrist _____ Physiatrist _____ other _____

Signature of medical provider: _____

Name of provider (please print): _____ Phone number: _____

To be completed by parent/guardian:

I agree with the above recommendations and would like them to be implemented: Yes _____ No _____

The best number to reach me during the day to discuss my child's plan for school is _____

RELEASE OF INFORMATION: I give permission for the school nurse/school personnel to exchange information regarding my child's care following the concussion with the provider/office listed above. YES _____ NO _____

Parent signature: _____ Date: _____

Form was received and reviewed by:

Name: _____ Signature: _____ Date: _____

If applicable, this form was copied and provided on this date _____ to:

<input type="checkbox"/> Grade level team	<input type="checkbox"/> Fine arts team	<input type="checkbox"/> Enrichment	<input type="checkbox"/> 504 Coordinator	<input type="checkbox"/> Athletic Director	<input type="checkbox"/> Coach
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