CONCUSSION ACKNOWLEDGEMENT FORM

Name of Student _____

Definition of Concussion - means a complex pathophysiological process affecting the brain caused by a traumatic physical force or impact to the head or body, which may: (A) include temporary or prolonged altered brain function resulting in physical, cognitive, or emotional symptoms or altered sleep patterns; and (B) involve loss of consciousness.

Prevention – Teach and practice safe play & proper technique.
- Follow the rules of play.
- Make sure the required protective equipment is worn for all practices and games.
- Protective equipment must fit properly and be inspected on a regular basis.

Signs and Symptoms of Concussion – The signs and symptoms of concussion may include but are not limited to: Headache, appears to be dazed or stunned, tinnitus (ringing in the ears), fatigue, slurred speech, nausea or vomiting, dizziness, loss of balance, blurry vision, sensitive to light or noise, feel foggy or groggy, memory loss, or confusion.

Oversight - Each district shall appoint and approve a Concussion Oversight Team (COT). The COT shall include at least one physician and an athletic trainer if one is employed by the school district. Other members may include: Advanced Practice Nurse, neuropsychologist or a physician's assistant. The COT is charged with developing the Return to Play protocol based on peer reviewed scientific evidence.

Treatment of Concussion - The student-athlete/cheerleader shall be removed from practice or participation immediately if suspected to have sustained a concussion. Every student-athlete/cheerleader suspected of sustaining a concussion shall be seen by a physician before they may return to athletic or cheerleading participation. The treatment for concussion is cognitive rest. Students should limit external stimulation such as watching television, playing video games, sending text messages, use of computer, and bright lights. When all signs and symptoms of concussion have cleared and the student has received written clearance from a physician, the student-athlete/cheerleader may begin their district's Return to Play protocol as determined by the Concussion Oversight Team.

Return to Play - According to the Texas Education Code, Section 38.157:
A student removed from an interscholastic athletics practice or competition (including per UIL rule, cheerleading) under Section 38.156 may not be permitted to practice or participate again following the force or impact believed to have caused the concussion until:
(1) the student has been evaluated, using established medical protocols based on peer-reviewed scientific evidence, by a treating physician chosen by the student or the student 's parent or guardian or another person with legal authority to make medical decisions for the student;
(2) the student has successfully completed each requirement of the return-to-play protocol established under Section 38.153 necessary for the student to return to play;
(3) the treating physician has provided a written statement indicating that, in the physician 's professional judgment, it is safe for the student to return to play; and
(4) the student and the student 's parent or guardian or another person with legal authority to make medical decisions for the student:
(A) have acknowledged that the student has completed the requirements of the return-to-play protocol necessary for the student to return to play;
(B) have provided the treating physician 's written statement under Subdivision (3) to the person responsible for compliance with the return-to-play protocol under Subsection (c) and the person who has supervisory responsibilities under Subsection (c); and
(C) have signed a consent form indicating that the person signing:
(i) has been informed concerning and consents to the student participating in returning to play in accordance with the return-to-play protocol;
(ii) understands the risks associated with the student returning to play and will comply with any ongoing requirements in the return-to-play protocol;
(iii) consents to the disclosure to appropriate persons, consistent with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), of the treating physician 's written statement under Subdivision (3) and, if any, the return-to-play recommendations of the treating physician; and
(iv) understands the immunity provisions under Section 38.159.

_____ _____
Parent or Guardian Signature *Date*

_____ _____
Student Signature *Date*

RETURN-TO-PLAY PROTOCOL FOLLOWING CONCUSSION

The athlete must meet all the following criteria in order to progress to activity:

- Asymptomatic at rest and with normal activities (including mental exertion in school)
- Demonstrate normal scores on cognitive assessment (e.g., SCAT™) as determined by a neuropsychologist or a physician trained with expertise in concussion management and interpretation of neurocognitive test results.

Once the above criteria are met, the athlete can progress back to full sports participation following a step-wise progression, preferably under the direct supervision of an Athletic Trainer. Progression is individualized and will be determined on a case by case basis. Factors that may affect the rate of progression include: acute markers of injury (e.g., loss of consciousness or amnesia); previous history of head injury/concussion; duration and type of symptoms; age of athlete; and sport or activity in which the athlete participates.

STEP-WISE PROGRESSION: The athlete should be held out of all activities until asymptomatic at rest for at least 24 hours though it is preferred to be asymptomatic for at least a 48 hour period. This asymptomatic period includes mental exertion in school to help reduce the re-emergence of symptoms once initiating the return to play protocol.

PLEASE NOTE: If any concussive symptoms occur while returning to play, the athlete should stop all activity until asymptomatic for another 1-2 days. Once symptoms resolve, resume with the phase in which the athlete was previously asymptomatic (back to previous successful phase).

DO NOT PROGRESS MORE THAN ONE STEP PER DAY THROUGH THIS PROTOCOL. Each step should take a minimum of ONE day (24 hour period) to complete in order to evaluate for any post-concussion symptoms that may occur during aerobic activity or between exertional sessions. Proceed to the next level ONLY if asymptomatic at the current level and throughout the recovery period. If the next progression step occurs over a weekend, only advance ONE step, not two, to allow for the protocol supervisor to review any post-concussion symptoms that may occur.

STEP	Rehabilitation Stage	Functional Exercise at Each Stage of Rehabilitation	Objective of Each Stage
1.	Light aerobic exercise	Light aerobic activity (10-15 mins) **Ex: Stationary bike, walking, etc.** NO resistance training.	Increase HR
2.	Moderate aerobic exercise	Moderate aerobic activity (20-30 mins) **Ex: Jogging, Elliptical, Stationary Bike, Etc**. Light resistance training.	Increase HR, cardiovascular endurance
3.	Sport-specific, non-contact	General, individual sport-specific drills without contact; NO head impact activities; Continue LIGHT resistance training.	Add movement, change of direction
4A.	Sport-specific, light-contact	Progression to more complex, light contact sport-specific Training drills with NO live opponent contact drill, (e.g., Passing drills in football or soccer, sleds in football); Progressive return to head impact activities. Progressive return to normal resistance training.	Exercise, coordination, and cognitive load
4B.	Full contact practice	Progress to participate in normal Training activities but NO games or competition play.	Restore confidence and assess functional skills by coaching staff.
5.	Full sports participation	Return to FULL sports participation. Normal game play As tolerated, monitor symptoms. (Note: In absence of competition , off-season athletes must complete an additional Phase 4b lieu of Phase 5 to fulfill RTP requirements	

SBISD Return-to-Play Post-Concussion

Instructions for Middle School Coaches

1. When a Head Injury Occurs:
   A. Using the *Head Injury Referral Form*:
      - Complete the top part of the form.
      - Call the parent/send the student to the doctor.
      - The physician should complete their part of the form and return it with the student to you.

   B. Have the parent complete the *SBISD Home Instructions for Head Injury Form*
      - The coach keeps the white copy.

2. Contact the high school athletic trainer, middle school nurse and the SBISD Athletic Department to notify them of student injury.

   A. Create a folder using the *SBISD Middle School Concussion Folder Checklist* for the student-athlete so all materials may be placed in the folder to take to the HS athletic trainer when the student-athlete is ready to be released.

3. Using the ***Spring Branch ISD Post-Concussion Symptom Checklist:***

   A. The middle school nurse/campus designee will document the student-athlete's condition daily on the checklist. Multiple checklist forms may be used during the documentation process.

   B. The student must be symptom-free before they are allowed to engage in physical activity.

   C. Refer to Phase I of the ***Stepwise Return-to-Play Documentation Checklist*** to begin progression into full activity.

4. Using the ***Stepwise Return-to-Play Documentation Checklist:***

   A. Go through Phases 1 through 4B.

   B. Multiple checklist forms may be used during the documentation process.

   C. If the student-athlete experiences any post-concussion symptoms, they must revert back to the previous phase of activity, after being symptom free for 24 hours.

5. Contact the high school athletic trainer or middle school nurse with any questions or concerns. Notify them of the student's progress within each phase.

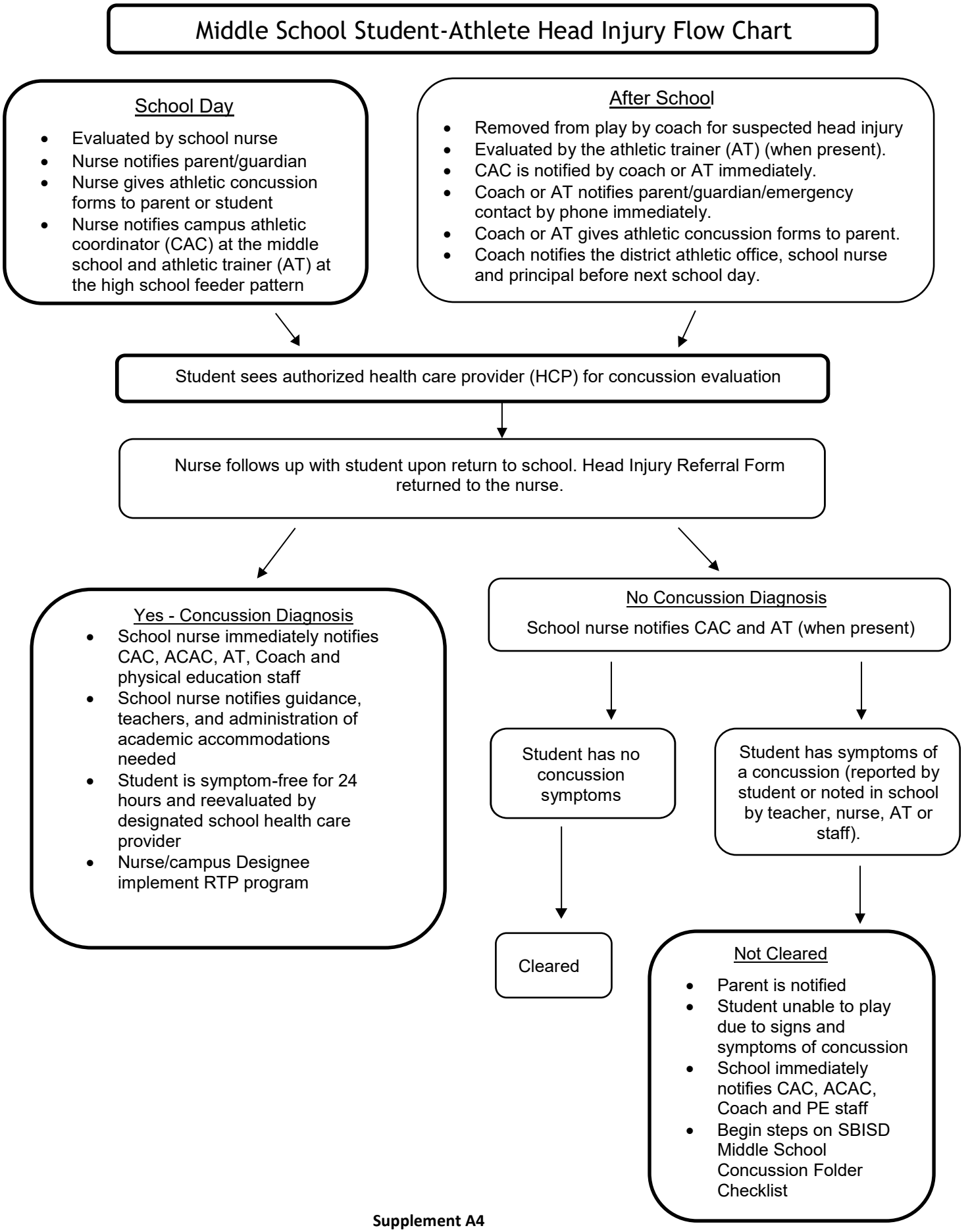
6. A meeting with the high school athletic trainer must be set up so that he/she can review all forms, evaluation checklists, and meet with the student-athlete before signing off on the ***UIL Concussion Management Protocol Return-to-Play Form***.

    A. The parent and athletic trainer must sign off on the ***UIL Concussion Management Protocol Return-to-Play Form*** before a student-athlete may begin competition after a concussion.

    B. A coach does not have the authority to allow a student-athlete to return to play after a concussion.

7. Once all forms are complete, scan and upload all completed Return-to-Play documents to the SBISD electronic filing system.

Middle School Student-Athlete Head Injury Flow Chart



SBISD Middle School Post-Concussion Protocol Checklist

Athlete's Name:_____ **Student ID** _____

Grade:_____ **Sport:** _____

- ☐ **Head Injury Referral Form**
  - o Complete top of form
  - o Call Parent
  - o Refer to Doctor
  - o Doctor completes form
  - o Head Injury Form returned with student-athlete to Athletic Trainer/M.S. nurse & coach
  - o Start folder for athlete, using the MS Concussion Folder Checklist, to collect all paperwork specific to concussion
- ☐ **Home Instructions for Head Injury**
  - o Parent completes form
- ☐ **Contact:**
  - o Athletic Trainer
  - o Middle School Nurse
  - o Athletic Department
- ☐ **Complete:**
  - o **Post-Concussion Symptom Checklist Daily Until Cleared** (Nurse/Campus Designee)
- ☐ **Stepwise Return-to-Play Documentation Checklist**
  - o Phase 1
  - o Phase 2
  - o Phase 3
  - o Phase 4A
  - o Phase 4B
- ☐ **Contact: About progress**
  - o Athletic Trainer
  - o Middle School Nurse
  - o Athletic Department
- ☐ **Send *UIL Concussion Management Protocol Return-to-Play* form home to be signed by parent. (Supplement C3)**
- ☐ **Meet with High School Athletic Trainer to review folder and sign on appropriate forms and evaluations**
- ☐ **Stepwise Return-to-Play Protocol**
  - o Phase 5-Return to FULL sports participation
  - o ***Note: In absence of competition, off-season athletes must complete an additional Phase 4b in lieu of Phase 5 to fulfill RTP requirements.*
- ☐ **Upload all completed Return-to-Play documents to the SBISD electronic filing system**

Completed by: _____

SBISD Middle School Concussion Folder Checklist

Athlete's Name: _____ **Student ID:** _____

Grade: _____ **Sport:** _____

☐Post-Concussion Check List

☐Completed Head Injury Referral Form with Dr. recommendations

☐Home Instructions for Head Injury Signed

☐Post-Concussion Symptom Check List(s) completed

☐Stepwise Return-to-Play Documentation Checklist completed

☐UIL Concussion Management Protocol Return-to-Play Form Signed

☐All Dr. notes relating to this concussion, including follow up appointments

Completed by:_____

Approved by: _____

HEAD INJURY REFERRAL FORM

ATHLETEINFORMATION

Name:_____ Sport:_____ Date: _____

Condition Occurred: [ ] Practice [] Competition [ ] Club Sport [ ] Home [ ] Other: _____

Mechanism of Injury: _____

Signs observed	Signs reported by athlete	Athlete data
__ Appears to be dazed or stunned __ Is confused about assignment __ Forgets plays __ Is unsure of game, score, or opponent __ Moves clumsily __ Answers questions slowly __ Loses consciousness (even temporarily) __ Shows behavior or personality change __ Forgets events prior to hit (retrograde amnesia) __ Forgets events after hit (anterograde amnesia)	__Headache __ Nausea __Balance problems or dizziness __ Double or fuzzy vision __Sensitivity to light or noise __ Feeling sluggish __ Feeling "foggy" __ Change in sleep pattern __ Concentration or memory problems	_____Height (inches) _____ Weight (pounds) _____ Number of previous concussions _____Years playing this sport

Other:_____

Observations reported by(name):_____ **Title:** _____

STEP-WISE RETURN-TO-PLAY PROTOCOL (Athlete will only advance ONE phase per day):

Per UIL rule and HB 2038, athletes must complete the following stepwise process prior to return to play following a concussion:

1. **Removal from contest/practice following any signs/symptoms of concussion**
2. **No return to play in current game/practice**
3. **Medical evaluation following injury**
4. **Stepwise Return to Play**

No activity and rest until symptom free

a. PHASE 1 - Light aerobic activity (10-15 minutes); no resistance training.
b. PHASE 2 - Moderate aerobic activity (20-30 minutes); light resistance training.
c. PHASE 3 - Sport-specific drills, no contact drills; progressive return to normal resistance training.
d. PHASE 4A - Sport-specific drills, light contact drills; progressive return to normal resistance training.
e. PHASE 4B - Full-contact drills but NO games or competition play.
f. PHASE 5 – FULL participation in games or competition play. In absence of competition, off-season athletes must complete an additional Phase 4b in lieu of Phase 5 to fulfill RTP requirements.

NOTE – Athlete activity progression continues as along as athlete is asymptomatic at current level. If athlete experiences any post-concussion symptoms, stop physical activity until symptom free for 24 hours. If any concussive symptoms occur while returning to play, the athlete should stop all activity until asymptomatic for another 1-2 days. Once symptoms resolve, resume with the phases in which the athlete was previously asymptomatic (back to previous successful phase).

ALL ATHLETES MUST SUCCESSFULLY COMPLETE THE STEPWISE RETURN-TO-PLAY PROTOCOL PRIOR TO BEING ALLOWED TO COMPETE IN A GAME OR COMPETITION IN ACCORDANCE WITH H.B. 2038.

PHYSICIAN INFORMATION

Diagnosis: _____ Concussion/ restrictions/ NO clearance _____ NO concussion/ NO restrictions/ Full clearance

The above named athlete was referred due to having signs/symptoms of a mild traumatic brain injury (MTBI). It is my professional judgment that the athlete may begin the Return-to-Play protocol once asymptomatic. Once the athlete has completed the Return-to-Play protocol, he/she is able to return to full-unrestricted sports participation.

_____ Athlete is **NOT CLEARED** at this time and is not allowed to participate in the Return-to-Play protocol. Athlete is to return to clinic for further evaluation on: _____

_____ Athlete is **CLEARED** to begin the required Return-to-Play protocol once asymptomatic, under the supervision of the Athletic Trainer, or school nurse, and designated coach. Once the athlete completes the protocol successfully, he/she does not need to return and is cleared for full sports participation.

_____ Athlete is cleared to begin the required Return-to-Play protocol under the supervision of the Athletic Trainer, or school nurse, and designated coach. Once the athlete completes the protocol successful, he/she **MUST RETURN FOR RE-EVALUATION** before being cleared for unrestricted sports**.**

Physician Name Printed:_____

Physician Signature:_____ **Date:**_____

Physician Address: _____

Physician Telephone:_____ **Physician fax:** _____

Athletic Trainer or school nurse clearance is required for full unrestricted participation.

Signature:_____ **Date:** _____

Spring Branch ISD
Home Instructions for Head Injury

_____ (athlete name) is being monitored for the possibility of a head injury, called a concussion on _____ (date) while participating in an athletic event. The following are instructions for this person's care over the next few days.

1 Do not drive a vehicle
2 Rest. No physical activity (full physical rest)
3 No TV/Video Games/Computer/Text Messaging
4 Do not take Aspirin or Ibuprofen (Advil, Motrin) or Naproxen (Aleve)
5 Tylenol (Acetaminophen) may be acceptable
6 You may sleep, but should be checked on periodically if exhibiting moderate to severe symptoms

Signs and symptoms of a closed head injury do not always present until hours or sometimes days after the initial trauma. Due to this fact, you should be aware of possible signs and symptoms that indicate a significant head injury including but not limited to the following.

1 Persistent or repeated vomiting
2 Convulsions/seizure
3 Vision changes
4 Any peculiar movements of the eyes, or if one pupil is larger than the other
5 Restless, irritability, or drastic changes in emotional control
6 Difficulty walking
7 Difficulty speaking or slurred speech
8 Progressive or sudden impairment of consciousness
9 Bleeding or drainage of fluid from the nose or ears
10 Any other abnormal behavior and/or sign or symptom

If any of the above occurs call an ambulance or take the athlete to the hospital Emergency Room.

Emergency Phone Numbers: **EMS- 911**

Supervising School Official:_____

Athletic Trainer:_____ **Office/Cell Number:**_____

Parent/Guardian Contact: Yes No Notes: _____

SBISD athletes who have sustained a concussion will be required to follow up with their licensed athletic trainer or middle school coach and school nurse each day until cleared by a physician. Although cleared by a physician, the athlete must still pass the progressive Return-to-Play protocol before they will be considered for release to full activity. (HB 2038, Natasha's Law)

Student Signature:_____ **Date:**_____

Parent/Guardian Signature:_____ **Date:**_____

Supplement C1

Spring Branch ISD Post-Concussion Symptom Checklist

Name of Athlete: Report Administrator:

Please use this scale to rate each symptom	None		Mild		Moderate		Severe
	0	1		2	3	4	5

Date & Time		
Reported Symptoms	**Pre**	**Post**
Headache		
Nausea		
Vomiting		
Balance Problems		
Dizziness		
Lightheadedness		
Fatigue		
Trouble falling asleep		
Sleeping more than usual		
Sleeping less than usual		
Drowsiness		
Sensitivity to light		
Sensitivity to noise		
Irritability		
Sadness		
Nervous/Anxious		
Feeling more emotional		
Numbness or tingling		
Feeling slowed down		
Feeling like "in a fog"		
Difficulty concentrating		
Difficulty remembering		
Visual problems		
Other		
Total		

Phase:__________

Comments:________________________________

____

Date & Time		
Reported Symptoms	**Pre**	**Post**
Headache		
Nausea		
Vomiting		
Balance Problems		
Dizziness		
Lightheadedness		
Fatigue		
Trouble falling asleep		
Sleeping more than usual		
Sleeping less than usual		
Drowsiness		
Sensitivity to light		
Sensitivity to noise		
Irritability		
Sadness		
Nervous/Anxious		
Feeling more emotional		
Numbness or tingling		
Feeling slowed down		
Feeling like "in a fog"		
Difficulty concentrating		
Difficulty remembering		
Visual problems		
Other		
Total		

Phase:________

Comments:_________________________________

____

Date & Time		
Reported Symptoms	**Pre**	**Post**
Headache		
Nausea		
Vomiting		
Balance Problems		
Dizziness		
Lightheadedness		
Fatigue		
Trouble falling asleep		
Sleeping more than usual		
Sleeping less than usual		
Drowsiness		
Sensitivity to light		
Sensitivity to noise		
Irritability		
Sadness		
Nervous/Anxious		
Feeling more emotional		
Numbness or tingling		
Feeling slowed down		
Feeling like "in a fog"		
Difficulty concentrating		
Difficulty remembering		
Visual problems		
Other		
Total		

Phase:_______

Comments:_________________________________

____

*****This form must be completed daily (Nurse/Campus Designee)

Supplement C2

Stepwise Return-to-Play Documentation Checklist

Athlete Name: **Date of Injury:**

No physical activity until student-athlete is symptom free for 24 hours and receives written clearance from a physician using the Head Injury Referral Form.

Date	Level	Description of Activity	*Symptoms Reported	Coach/LAT	Athlete
	Phase 1- Light aerobic exercise, walking or stationary bike, 10-15 minutes, <70% max heart rate. **NO** resistance training.				
	Phase 2-Moderate aerobic exercise, stationary bike, elliptical, jogging keeping intensity <85% max heart rate. Begin light resistance training.				
	Phase 3-Sport-specific drills without contact; **NO** head impact activities. Continue Light resistance training.				
	Phase 4A- Sport-specific drills, light contact drills with **NO** live opponent contact drills. Progressive return to normal resistance training.				
	Phase 4B- Full contact drills; participate in normal training activities but **NO** games or competition play.				
	Phase 5- Return to FULL sports participation. A SBISD Athletic Trainer is the only SBISD employee allowed to release an athlete to unrestricted activity. ***Note: In absence of competition, off-season athletes must complete an additional Phase 4b in lieu of Phase 5 to fulfill RTP requirements.*				

***If the student-athlete experiences any post-concussion symptoms during the return to activity progression, activity is discontinued and the student-athlete must be re-evaluated by a licensed health care professional.**

** In order for an athlete to be released to unrestricted activity, the following documents must be completed and returned to the athletic trainer.

1. The Head Injury Referral Form
2. The UIL Return-to-Play Form (The athletic trainer will act as the designated school district official and fill out that portion of the form)
3. The Post-Concussion Symptom Check (This form will be filled out by the school nurse/campus designeeat the Middle School level)
4. The Stepwise Return-to-Play Documentation Checklist

Concussion Management Protocol Return to Play Form

This form must be completed and submitted to the athletic trainer or other person (who is not a coach) responsible for compliance with the Return to Play protocol established by the school district Concussion Oversight Team, as determined by the superintendent or their designee (see Section 38.157 (c) of the Texas Education Code).

_____ _____

Student Name (Please Print) *School Name (Please Print)*

Designated school district official verifies:

Please Check

☐ The student has been evaluated by a treating physician selected by the student, their parent or other person with legal authority to make medical decisions for the student.

☐ The student has completed the Return to Play protocol established by the school district Concussion Oversight Team.

☐ The school has received a written statement from the treating physician indicating, that in the physician's professional judgment, it is safe for the student to return to play.

_____ _____

School Individual Signature *Date*

_____

School Individual Name (Please Print)

Parent, or other person with legal authority to make medical decisions for the student signs and certifies that he/she:

Please Check

☐ Has been informed concerning and consents to the student participating in returning to play in accordance with the return to play protocol established by the Concussion Oversight Team.

☐ Understands the risks associated with the student returning to play and will comply with any ongoing requirements in the return to play protocol.

☐ Consents to the disclosure to appropriate persons, consistent with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), of the treating physician's written statement under Subdivision (3) and, if any, the return to play recommendations of the treating physician.

☐ Understands the immunity provisions under Section 38.159 of the Texas Education Code.

_____ _____

Parent/Responsible Decision-Maker Signature *Date*

_____

Parent/Responsible Decision-Maker Name (Please Print)