HARRISON CENTRAL SCHOOL DISTRICT

50 Union Avenue, Harrison, NY 10528

Concussion Management Protocol

Concussion Clearance Form for Students Who Do Not Participate in Interscholastic Athletics

(Completed by Student's Physician)

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

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**

Can the student return to physical activity (e.g., physical education and recess) after 24 hours of rest? ☐ **Yes** ☐ **No**

Does the student require a gradual return to activity? ☐ **Yes (specify on reverse side of form)** ☐ **No**

List any specific learning accommodations (e.g., reduced schedule, limit screen time, etc.) or physical activity restrictions (e.g., no contact sports, gradual return to activity, etc.) required at school and the duration of these accommodations and restrictions.

_____

_____

_____

_____

Physician Name:_____ Date:_____

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

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Return to Activity Progression

Level 1: Light Aerobic Exercise ☐ **Yes** ☐ **No**

- 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 to make sure they are symptom free. If student continues to be symptom free, then advance to Level 2 on the next day.

Level 2: Moderate Exercise ☐ **Yes** ☐ **No**

- The Goal: limited body and head movement.
- The Time: Reduced from typical routine-15-20 minutes
- The Activities: walk/jog moderately for 10 minutes and complete 20 jumping jacks. Check in with student to make sure they are symptom free. If student continues to be symptom free, then advance to Level 3 the next day.

Level 3: Non-contact Exercise ☐ **Yes** ☐ **No**

- The Goal: more intense but non-contact
- The Time: Close to Typical Routine 30-40 minutes
- The Activities: walk/jog moderately for 10 minutes and complete 20 jumping jacks and 5 deep knee bends, 10 sit ups. Check in with student to make sure they are symptom free. If student continues to be symptom free, then they should be reinstated to full participation in physical education class and recess the next day.

Additional Notes or Modifications to the Return to Activity Progression:

_____

_____

_____

_____

_____

Physician Name:_____ Date:_____

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