# New Caney ISD

# CONCUSSION MANAGEMENT PROTOCOL

**NOTE: Revisions to the guidelines recommended in this Concussion Management Protocol will be made annually upon current legislation and further understanding and interpretation of H.B. 2038 (2011). Last revised, July 2022.**

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**Concussion Management Overview**

Memorial Hermann Sports Medicine and the Rockets Sports Medicine Institute Concussion Program at Memorial Hermann have developed and implemented the following concussion management guidelines for the student-athletes in NCISD ISD. These comprehensive guidelines are consistent with current standards of care and appropriate medical practices for the student-athlete who is believed or suspected to have a concussion. In cooperation with NCISD ISD, Memorial Hermann has developed and implemented a Concussion Oversight Team (COT) illustrated in the section below. The following guidelines are designed to facilitate a safe return to play for the student-athletes of NCISD ISD. The COT is committed to utilizing current standards and methods in its multidisciplinary approach to concussion management which may include, but not limited to pre- and post-injury neurocognitive testing (e.g., ImPACT, current Sport Concussion Assessment Tool (SCAT-5), graded symptom checklist, progressive return-to-play (RTP) protocol, and other potentially recommended testing/evaluation tools.

| NCISD ISD **CONCUSSION OVERSIGHT TEAM (COT)** | |
|---|---|
| Physician | Jay Muscat, MD, Irvin Sulapas, MD |
| District employed athletic trainer and/or school nurse | All ISD employed athletic trainer(s) & ISD Nurse(s) |
| Neuropsychologist | Summer Ott, PsyD |
| Other COT members | Outreach athletic trainer(s) |

Any student-athlete removed from a workout, practice or competition due to the recognition of concussion-related signs and symptoms will not be allowed to return to any participation for the remainder of that day. If the student-athlete is believed or suspected to have suffered concussion, he/she must be cleared to begin and complete NCISD ISD adopted RTP protocol before resuming full, unrestricted participation by a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.)

The student-athlete must provide a written statement from the evaluating physician indicating that, in the physician's professional judgment, it is safe for the student-athlete to return to play. The student-athlete's parent or guardian and the student-athlete must then sign and return to the school district designee the UIL Concussion Management Protocol RTP Form indicating the following: They have been informed and consent to the policies established under the RTP Protocol; they understand the risks associated with the student-athlete returning to play; they agree to comply with any requirements outlined by the concussion policy; they consent to the physician's disclosure of health information that was related to the concussion and treatments; and they understand the district's and school's immunity from liability.

**NOTE**: If a student-athlete is experiencing symptoms for an extended period of time and the physician prescribes Sub-Maximal Threshold/Concussion Rehabilitation, this is not considered part of the RTP protocol. It is considered rehabilitation and a way to get the student-athlete more active in a controlled and supervised fashion.

**Concussion Management Timeline**

1. All required UIL/TAPPs/District paperwork is completed and signed by the student-athlete and his/her parent/guardian or another person with legal authority to make medical decisions for the student prior to athletic participation.

2. Pre-Season Neurocognitive Baseline Assessment (if utilized)

   Baseline testing should accompany each level of participation (e.g., 7th grade, 9th grade). If a student-athlete suffered a concussion, a new baseline examination is recommended when RTP protocol is completed and unrestricted participation is determined.

   a. ImPACT™ Baseline Testing (if utilized) – [Supplement A-1; A-2; A-3; A-4]

   > According to the Centers for Disease Control and Prevention (CDC), only a physician or neuropsychologist trained in concussion management should interpret neurocognitive tests. When possible, ideally a neuropsychologist should interpret the computerized (ImPACT™) or paper-pencil neuropsychological test components. Remember that results of neuropsychological tests should not be used as a stand-alone diagnostic tool, but should serve as one component used by trained healthcare professionals to make a return to school and play decisions.

   b. SCAT-5 Baseline Assessment (recommended) – [Appendix B-1, pg. 12]

3. On-Field Sideline Evaluation

   If the student-athlete has any observable signs and/or reports any symptoms of a concussion the student-athlete must be removed from participation and be further evaluated.

   If the student-athlete is unable to get up on his or her own after a hit, collision, or fall, it should be assumed that a loss of consciousness has occurred and the student-athlete may have sustained a cervical spine injury. The student-athlete should be stabilized and transported immediately to hospital emergency department via ambulance.

   If the student-athlete is conscious and able to be assisted to the sideline, the athletic trainer or physician will administer one of the sideline assessment tools
   [Sports Concussion Assessment Tool (SCAT-5)] – [Appendix B-1, pg. 12]
   [Graded Symptom Checklist (GSC)] – [Appendix B-2, pg. 16]

   The student-athlete will continue to be monitored for approximately 15-20 minutes and reassessed every 5 minutes for any signs of deterioration, (e.g., worsening headache, seizures or convulsions, focal neurological deficits, altered state of consciousness, repeated vomiting, slurred speech, or increasing confusion or irritability). If the student-athlete demonstrates any signs of deterioration, he or she will be transported immediately to a hospital emergency department via ambulance.

**Concussion Management Timeline (Continued)**

The student-athlete will be removed from participation and will not return to participation (practice or game) on the same day they were injured regardless of how long the concussive symptoms persist, improve, or clear completely. At this point the student-athlete must see a physician (see #5).

4. Athletic trainer evaluation (if available on-site)

   The athletic trainer must be notified as soon as possible that concussion signs and/or symptoms have been observed and the student-athlete needs evaluation.

   The athletic trainer will perform a complete evaluation whenever possible.

5. A referral to a physician or other appropriate healthcare professional will be provided.

   The student-athlete must be seen by a physician and cleared to begin NCISD ISD RTP protocol.

6. Home care instructions for the student-athlete will be provided to his or her Parent/Guardian.

   This information is to educate the parent or guardian of the signs and symptoms of a concussion as well as those to monitor for any deterioration. If any signs of deterioration occurs once the student-athlete leaves the school, the parent or guardian will be informed of the proper protocol to follow.

   [Concussion Management Instructions] – [Appendix C, pg. 17]
   [Guide for Physician Referral] – [Appendix D, pg. 18]

7. The student-athlete must provide a written statement from his or her evaluating physician indicating that, in the physician's professional judgment, it is safe for the student-athlete to return to play. The completed and signed "Concussion Management Physician Clearance Form" must be on file with the athletic trainer prior to any RTP protocol.

   Student-athletes evaluated for a concussion in a hospital emergency room or urgent care clinic will not be allowed to begin the RTP protocol until they have been evaluated by a physician specially trained in concussion management or their primary care physician.

   STEPWISE RTP PROTOCOL: With the written physician's statement on file, the student-athlete will progress through the stepwise NCISD ISD RTP protocol. The student-athlete cannot advance more than ONE step or phase per day. If the progression occurs over a weekend, summer, or holiday break, the student-athlete is not to progress more than one step until the next school day, unless specifically directed and supervised by the athletic trainer or superintendent's designee (e.g., school nurse, coach). This allows the supervisor to evaluate any symptoms which may occur after activity during the recovery period and authorize continued progression.

   [Return-to-Play Protocol Following Concussion] – [Appendix F, pg. 20]

**Concussion Management Timeline (Continued)**

8. RTP Guidelines for Parents: Once the student-athlete has successfully progressed through each step or phase of NCISD ISD RTP protocol and continues to stay asymptomatic throughout the recovery period, the athletic trainer or superintendent's designee and the parent/guardian complete the UIL Concussion Management Protocol RTP form.
   [UIL Concussion Management Protocol Return-to-Play Form] – [Appendix H-1, pg. 22]

9. All required paperwork should be collected and verified with proper signatures of the student-athlete, parent/guardian, and the athletic trainer or superintendents' designee are on file prior to the student-athlete's return to full, unrestricted sports participation/competition.

**Post-Concussion Management at School – Middle School**

1. Middle-school athletes will complete the RTP Protocol (same as High School steps below) under the guidance of the athletic trainer. If no athletic trainer is available, the school nurse or superintendent's designee will oversee the RTP Protocol.

**Post-Concussion Management at School – High School**

1. As soon as possible, school personnel (e.g., assistant principal; counselor or modifications counselor; school nurse; teachers) will be notified of the student-athlete's concussion.

2. School personnel will be provided with an educational handout outlining the observable signs and reported symptoms of a concussion.
   [Concussion Fact Sheet] – [Appendix A, pg. 10]

   a. Second Impact syndrome refers to a catastrophic series of events which may occur when a second concussion occurs while the athlete is still symptomatic from a previous concussion. A second injury may occur within hours, days, weeks, or even months following the first injury. Loss of consciousness is not required to determine second impact syndrome. Often times, second impact syndrome occurs when an athlete returns to activity before he or she is symptom-free from the previous concussion.

3. Academic Modifications

   Some student-athletes may be able to attend school without an increase of post-concussion symptoms.

   A physician, neurologist, neuropsychologist, or other specialist involved in the student-athlete's care may recommend that the student be given special academic accommodations, (e.g., postponement or reducing exams/quizzes, reducing workload, provide pre-printed class notes, additional time to complete assignments, assistance to class, limited computer work, reading activities, etc.), until symptoms subside to allow for full recovery potential. Many student-athletes will require one or more academic adjustments depending on the nature of their injury and post-concussion symptoms, to allow for the best recovery outcome.
   [Post-Concussion Cognitive Recommendations/Modifications] – [Appendix I, pg. 23]

   | |
   |---|
   | Academic adjustments should only be made under the direct recommendation of the student-athlete's treating physician, neurologist, or neuropsychologist. For liability purposes the athletic trainer should not make these direct modifications but may recommend them to school personnel or their treating physician or specialist. |

   The treating physician, neurologist, neuropsychologist, or other specialist will provide the necessary documentation for the school district if any days or class time is to be missed.

**Post-Concussion Management at School – High School (Continued)**

Unrestricted return to sport will not occur prior to unrestricted return to learn. Student-athletes should be attending full days of school and no longer depending on extended time, breaks, reduced homework, or other specified adjustments made by the physician, neurologist, neuropsychologist, or other specialist. It is understood however, that some student-athletes may still be in the process of making up missed assignments and examinations when RTP is initiated.

| |
|---|
| Unrestricted return to learn applies to academic accommodations that were granted post-injury. Academic accommodations that were in place as part of a 504 plan prior to the injury may remain in place prior to unrestricted return to sport participation/competition. |

**Recovery and Safe Return to Play**

1. In addition to requiring a specific stepwise RTP, H.B. 2038 requires that the student-athlete and his/her parent or guardian, or another person with legal authority to make medical decisions for the student-athlete, are educated about risks associated with returning to play following a concussion.

2. It is crucial to allow enough healing and recovery time following a concussion to prevent further damage. Research has shown that damage from repeated concussions is cumulative. Many student-athletes who experience an initial concussion can recover completely as long as they do not return to play too soon. Following a concussion, there is a period of change in the function of the brain that can last from 24 -

**Return-to-Play Guidelines**

1. The treating physician must provide a written statement indicating that, in the physician's professional judgment, it is safe for the student to return to play. This written statement must be on file prior to any RTP protocol being initiated.
   [Concussion Management Physician Clearance Form] – [Appendix E, pg. 19]

2. ImPACT™ composite scores must be within normal limits when compared to baseline test scores, if utilizing ImPACT™. If a baseline test is not available, the test scores are compared to scores consistent with pre-injury, expected academic performance and cognitive abilities.

   > According to the Centers for Disease Control and Prevention (CDC), only a trained healthcare professional with experience in concussion management should interpret neurocognitive tests. When possible, ideally a neuropsychologist should interpret the computerized (ImPACT™) or paper- pencil neuropsychological test components. Remember that results of neuropsychological tests should not be used as a stand-alone diagnostic tool, but should serve as one component used by trained healthcare professionals to make a return to school and play decisions.

3. Parent information is provided and the UIL Concussion Management RTP Form must be signed by all necessary parties and on file.
   [Concussion Management Instructions] – [Appendix C, pg. 17]
   [Guide for Physician Referral] – [Appendix D, pg. 18]
   [UIL Concussion Management Protocol RTP Form] – [Appendix H-1, pg. 22]

4. progression is to be monitored by an athletic trainer. If an athletic trainer is not available, the student-athlete may have the RTP progression monitored by the superintendent's designee (e.g., coach or nurse employed by the school). Per H.B. 2038, a coach is not permitted to clear a student-athlete for full sports participation following a concussion. All student-athletes that are seen by a physician for a suspected concussion are required to complete the full RTP Protocol before they will be allowed to fully participate without restrictions.
   [Return-to-Play Protocol Following Suspected Concussion] – [Appendix F, pg. 20]

5. Written clearance from the athletic trainer or school nurse is required for full, unrestricted participation.
   [Return-to-Play Check Sheet] – [Appendix G, pg. 21]

# CONCUSSION FACT SHEET

**What is a concussion?**

A concussion is an injury to the brain. Concussions are caused by a bump, blow or jolt to the head or body. Concussions are serious injuries, no matter how mild the bump, blow or jolt may appear.

**What are the signs and symptoms?**

You can't see a concussion. Signs and symptoms of a concussion may appear immediately after the injury or may not appear or be noticed until days after the injury. If a student-athlete reports one or more of the symptoms listed below, or if you notice signs of a concussion yourself, keep the student-athlete out of practice and play, and seek medical attention immediately.

1. <u>OBSERVABLE SIGNS OF A CONCUSSION:</u>
    - Appears dazed or stunned
    - Confused about assignments or position
    - Forgets instructions or demands
    - Unsure of game; score; opponent
    - Clumsy Movements
    - Loss of Balance
    - Answers questions slowly; shows delayed response
    - Loses consciousness for any given amount of time
    - Retrograde amnesia (unable to recall events prior to bump/blow/jolt)
    - Anterograde amnesia (unable to recall events after bump/blow/jolt)

2. <u>SYMPTOMS OF A CONCUSSION REPORTS BY THE STUDENT-ATHLETE:</u>
    - Headache or "pressure in head"
    - Nausea or vomiting
    - Dizziness
    - Loss of Balance
    - Double vision; blurry vision
    - Sensitivity or light
    - Sensitivity or noise
    - Feeling sluggish; hazy; groggy; slowed down
    - Difficulty concentrating; memory problems
    - Confusion
    - "Not feeling right"; feeling emotional (sad – agitated – angry); feeling depressed or down

**What are the signs and symptoms? (Continued)**

3. DANGER SIGNS OF A CONCUSSION – **SEEK IMMEDIATE MEDICAL ATTENTION IF**:
    - Unequal, unreactive, or unusually dilated pupils; changes in pupil shape or size compared bilaterally
    - In and out of consciousness or complete loss of consciousness
    - A headache that gets worse and does not go away
    - Repeated vomiting or nausea
    - Slurred speech
    - Convulsions or seizures
    - Difficulty recognizing people or places
    - Increasingly worse confusion, restlessness, or agitation
    - Unusual behavior or conversation/speech
    - Notable increase or decrease in Blood Pressure
    - Decreased or irregular respirations or pulse
    - Abnormal posturing at time of injury (decerebrate; decorticate; fencing postures)
    - Deterioration of neurologic function (Loss of sensation; difficulty moving limb; numbness; decreased coordination)
    - Any signs or symptoms related to neck or spine injuries, skull fracture, or severe bleeding

# SCAT-5

1

## IMMEDIATE OR ON-FIELD ASSESSMENT

The following elements should be assessed for all athletes who are suspected of having a concussion prior to proceeding to the neurocognitive assessment and ideally should be done on-field after the first first aid / emergency care priorities are completed.

If any of the "Red Flags" or observable signs are noted after a direct or indirect blow to the head, the athlete should be immediately and safely removed from participation and evaluated by a physician or licensed healthcare professional.

Consideration of transportation to a medical facility should be at the discretion of the physician or licensed healthcare professional.

The GCS is important as a standard measure for all patients and can be done serially if necessary in the event of deterioration in conscious state. The Maddocks questions and cervical spine exam are critical steps of the immediate assessment; however, these do not need to be done serially.

## STEP 1: RED FLAGS

**RED FLAGS:**

- **Neck pain or tenderness**
- **Double vision**
- **Weakness or tingling/ burning in arms or legs**
- **Severe or increasing headache**
- **Seizure or convulsion**
- **Loss of consciousness**
- **Deteriorating conscious state**
- **Vomiting**
- **Increasingly restless, agitated or combative**

## STEP 2: OBSERVABLE SIGNS

Witnessed ☐ Observed on Video ☐

| | | |
|---|---|---|
| Lying motionless on the playing surface | Y | N |
| Balance / gait difficulties / motor incoordination: stumbling, slow / laboured movements | Y | N |
| Disorientation or confusion, or an inability to respond appropriately to questions | Y | N |
| Blank or vacant look | Y | N |
| Facial injury after head trauma | Y | N |

## STEP 3: MEMORY ASSESSMENT MADDOCKS QUESTIONS[2]

*"I am going to ask you a few questions, please listen carefully and give your best effort. First, tell me what happened?"*

**Mark Y for correct answer / N for incorrect**

| | | |
|---|---|---|
| What venue are we at today? | Y | N |
| Which half is it now? | Y | N |
| Who scored last in this match? | Y | N |
| What team did you play last week / game? | Y | N |
| Did your team win the last game? | Y | N |

**Note: Appropriate sport-specific questions may be substituted.**

Name: _____

DOB: _____

Address: _____

ID number: _____

Examiner: _____

Date: _____

## STEP 4: EXAMINATION GLASGOW COMA SCALE (GCS)[3]

| | | | |
|---|---|---|---|
| **Time of assessment** | | | |
| **Date of assessment** | | | |
| **Best eye response (E)** | | | |
| No eye opening | 1 | 1 | 1 |
| Eye opening in response to pain | 2 | 2 | 2 |
| Eye opening to speech | 3 | 3 | 3 |
| Eyes opening spontaneously | 4 | 4 | 4 |
| **Best verbal response (V)** | | | |
| No verbal response | 1 | 1 | 1 |
| Incomprehensible sounds | 2 | 2 | 2 |
| Inappropriate words | 3 | 3 | 3 |
| Confused | 4 | 4 | 4 |
| Oriented | 5 | 5 | 5 |
| **Best motor response (M)** | | | |
| No motor response | 1 | 1 | 1 |
| Extension to pain | 2 | 2 | 2 |
| Abnormal flexion to pain | 3 | 3 | 3 |
| Flexion / Withdrawal to pain | 4 | 4 | 4 |
| Localizes to pain | 5 | 5 | 5 |
| Obeys commands | 6 | 6 | 6 |
| **Glasgow Coma score (E + V + M)** | | | |

## CERVICAL SPINE ASSESSMENT

| | | |
|---|---|---|
| Does the athlete report that their neck is pain free at rest? | Y | N |
| **If there is NO neck pain at rest,** does the athlete have a full range of ACTIVE pain free movement? | Y | N |
| Is the limb strength and sensation normal? | Y | N |

**In a patient who is not lucid or fully conscious, a cervical spine injury should be assumed until proven otherwise.**

## OFFICE OR OFF-FIELD ASSESSMENT

**Please note that the neurocognitive assessment should be done in a distraction-free environment with the athlete in a resting state.**

## STEP 1: ATHLETE BACKGROUND

Sport / team / school: _____

Date / time of injury: _____

Years of education completed: _____

Age: _____

Gender: M / F / Other

Dominant hand: left / neither / right

How many diagnosed concussions has the athlete had in the past?: _____

When was the most recent concussion?: _____

How long was the recovery (time to being cleared to play) from the most recent concussion?: _____ (days)

**Has the athlete ever been:**

| | | |
|---|---|---|
| Hospitalized for a head injury? | Yes | No |
| Diagnosed / treated for headache disorder or migraines? | Yes | No |
| Diagnosed with a learning disability / dyslexia? | Yes | No |
| Diagnosed with ADD / ADHD? | Yes | No |
| Diagnosed with depression, anxiety or other psychiatric disorder? | Yes | No |

Current medications? If yes, please list:

_____

_____

_____

_____

_____

_____

Name: _____

DOB: _____

Address: _____

ID number: _____

Examiner: _____

Date: _____

2

## STEP 2: SYMPTOM EVALUATION

*The athlete should be given the symptom form and asked to read this instruction paragraph out loud then complete the symptom scale. For the baseline assessment, the athlete should rate his/her symptoms based on how he/she typically feels and for the post injury assessment the athlete should rate their symptoms at this point in time.*

**Please Check: ☐ Baseline ☐ Post-Injury**

**Please hand the form to the athlete**

| | none | mild | | moderate | | severe | |
|---|---|---|---|---|---|---|---|
| Headache | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| "Pressure in head" | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Neck Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Nausea or vomiting | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Dizziness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Blurred vision | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Balance problems | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Sensitivity to light | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Sensitivity to noise | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Feeling slowed down | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Feeling like "in a fog" | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| "Don't feel right" | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Difficulty concentrating | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Difficulty remembering | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Fatigue or low energy | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Confusion | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Drowsiness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| More emotional | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Irritability | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Sadness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Nervous or Anxious | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Trouble falling asleep (if applicable) | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Total number of symptoms: | | | | | | | of 22 |
| Symptom severity score: | | | | | | | of 132 |
| Do your symptoms get worse with physical activity? | | | | | | Y | N |
| Do your symptoms get worse with mental activity? | | | | | | Y | N |
| If 100% is feeling perfectly normal, what percent of normal do you feel? | | | | | | | |

If not 100%, why?

_____

_____

_____

**Please hand form back to examiner**

Name: _____

DOB: _____

Address: _____

ID number: _____

Examiner: _____

Date: _____

# STEP 3: COGNITIVE SCREENING

**Standardised Assessment of Concussion (SAC)[4]**

## ORIENTATION

| | | |
|---|---|---|
| What month is it? | 0 | 1 |
| What is the date today? | 0 | 1 |
| What is the day of the week? | 0 | 1 |
| What year is it? | 0 | 1 |
| What time is it right now? (within 1 hour) | 0 | 1 |
| **Orientation score** | | of 5 |

## IMMEDIATE MEMORY

The Immediate Memory component can be completed using the traditional 5-word per trial list or optionally using 10-words per trial to minimise any ceiling effect. All 3 trials must be administered irrespective of the number correct on the first trial. Administer at the rate of one word per second.

**Please choose EITHER the 5 or 10 word list groups and circle the specific word list chosen for this test.**

*I am going to test your memory. I will read you a list of words and when I am done, repeat back as many words as you can remember, in any order. For Trials 2 & 3: I am going to repeat the same list again. Repeat back as many words as you can remember in any order, even if you said the word before.*

| List | Alternate 5 word lists | | | | | Score (of 5) Trial 1 | Trial 2 | Trial 3 |
|---|---|---|---|---|---|---|---|---|
| A | Finger | Penny | Blanket | Lemon | Insect | | | |
| B | Candle | Paper | Sugar | Sandwich | Wagon | | | |
| C | Baby | Monkey | Perfume | Sunset | Iron | | | |
| D | Elbow | Apple | Carpet | Saddle | Bubble | | | |
| E | Jacket | Arrow | Pepper | Cotton | Movie | | | |
| F | Dollar | Honey | Mirror | Saddle | Anchor | | | |
| | | | | | **Immediate Memory Score** | | | of 15 |
| | | | | | **Time that last trial was completed** | | | |

| List | Alternate 10 word lists | | | | | Score (of 10) Trial 1 | Trial 2 | Trial 3 |
|---|---|---|---|---|---|---|---|---|
| G | Finger<br>Candle | Penny<br>Paper | Blanket<br>Sugar | Lemon<br>Sandwich | Insect<br>Wagon | | | |
| H | Baby<br>Elbow | Monkey<br>Apple | Perfume<br>Carpet | Sunset<br>Saddle | Iron<br>Bubble | | | |
| I | Jacket<br>Dollar | Arrow<br>Honey | Pepper<br>Mirror | Cotton<br>Saddle | Movie<br>Anchor | | | |
| | | | | | **Immediate Memory Score** | | | of 30 |
| | | | | | **Time that last trial was completed** | | | |

## CONCENTRATION

## DIGITS BACKWARDS

Please circle the Digit list chosen (A, B, C, D, E, F). Administer at the rate of one digit per second reading DOWN the selected column.

*I am going to read a string of numbers and when I am done, you repeat them back to me in reverse order of how I read them to you. For example, if I say 7-1-9, you would say 9-1-7.*

| Concentration Number Lists (circle one) | | | | | |
|---|---|---|---|---|---|
| List A | List B | List C | | | |
| 4-9-3 | 5-2-6 | 1-4-2 | Y | N | 0 |
| 6-2-9 | 4-1-5 | 6-5-8 | Y | N | 1 |
| 3-8-1-4 | 1-7-9-5 | 6-8-3-1 | Y | N | 0 |
| 3-2-7-9 | 4-9-6-8 | 3-4-8-1 | Y | N | 1 |
| 6-2-9-7-1 | 4-8-5-2-7 | 4-9-1-5-3 | Y | N | 0 |
| 1-5-2-8-6 | 6-1-8-4-3 | 6-8-2-5-1 | Y | N | 1 |
| 7-1-8-4-6-2 | 8-3-1-9-6-4 | 3-7-6-5-1-9 | Y | N | 0 |
| 5-3-9-1-4-8 | 7-2-4-8-5-6 | 9-2-6-5-1-4 | Y | N | 1 |
| List D | List E | List F | | | |
| 7-8-2 | 3-8-2 | 2-7-1 | Y | N | 0 |
| 9-2-6 | 5-1-8 | 4-7-9 | Y | N | 1 |
| 4-1-8-3 | 2-7-9-3 | 1-6-8-3 | Y | N | 0 |
| 9-7-2-3 | 2-1-6-9 | 3-9-2-4 | Y | N | 1 |
| 1-7-9-2-6 | 4-1-8-6-9 | 2-4-7-5-8 | Y | N | 0 |
| 4-1-7-5-2 | 9-4-1-7-5 | 8-3-9-6-4 | Y | N | 1 |
| 2-6-4-8-1-7 | 6-9-7-3-8-2 | 5-8-6-2-4-9 | Y | N | 0 |
| 8-4-1-9-3-5 | 4-2-7-9-3-8 | 3-1-7-8-2-6 | Y | N | 1 |
| | | **Digits Score:** | | | of 4 |

## MONTHS IN REVERSE ORDER

*Now tell me the months of the year in reverse order. Start with the last month and go backward. So you'll say December, November. Go ahead.*

| | |
|---|---|
| Dec - Nov - Oct - Sept - Aug - Jul - Jun - May - Apr - Mar - Feb - Jan | 0 1 |
| **Months Score** | of 1 |
| **Concentration Total Score (Digits + Months)** | of 5 |

4

## STEP 4: NEUROLOGICAL SCREEN

See the instruction sheet (page 7) for details of test administration and scoring of the tests.

| | | |
|---|---|---|
| Can the patient read aloud (e.g. symptom check-list) and follow instructions without difficulty? | Y | N |
| Does the patient have a full range of pain-free PASSIVE cervical spine movement? | Y | N |
| Without moving their head or neck, can the patient look side-to-side and up-and-down without double vision? | Y | N |
| Can the patient perform the finger nose coordination test normally? | Y | N |
| Can the patient perform tandem gait normally? | Y | N |

## BALANCE EXAMINATION

**Modified Balance Error Scoring System (mBESS) testing[5]**

Which foot was tested (i.e. which is the non-dominant foot) ☐ Left ☐ Right

Testing surface (hard floor, field, etc.) _____

Footwear (shoes, barefoot, braces, tape, etc.) _____

| Condition | Errors |
|---|---|
| **Double leg stance** | of 10 |
| **Single leg stance (non-dominant foot)** | of 10 |
| **Tandem stance (non-dominant foot at the back)** | of 10 |
| **Total Errors** | of 30 |

Name: _____

DOB: _____

Address: _____

ID number: _____

Examiner: _____

Date: _____

5

## STEP 5: DELAYED RECALL:

The delayed recall should be performed after 5 minutes have elapsed since the end of the Immediate Recall section. Score 1 pt. for each correct response.

*Do you remember that list of words I read a few times earlier? Tell me as many words from the list as you can remember in any order.*

**Time Started** _____

Please record each word correctly recalled. Total score equals number of words recalled.

_____

_____

_____

**Total number of words recalled accurately:** of 5 or of 10

6

## STEP 6: DECISION

| Domain | Date & time of assessment: | | |
|---|---|---|---|
| Symptom number (of 22) | | | |
| Symptom severity score (of 132) | | | |
| Orientation (of 5) | | | |
| Immediate memory | of 15<br>of 30 | of 15<br>of 30 | of 15<br>of 30 |
| Concentration (of 5) | | | |
| Neuro exam | Normal<br>Abnormal | Normal<br>Abnormal | Normal<br>Abnormal |
| Balance errors (of 30) | | | |
| Delayed Recall | of 5<br>of 10 | of 5<br>of 10 | of 5<br>of 10 |

Date and time of injury: _____

If the athlete is known to you prior to their injury, are they different from their usual self?
☐ **Yes** ☐ **No** ☐ **Unsure** ☐ **Not Applicable**
(If different, describe why in the clinical notes section)

Concussion Diagnosed?
☐ **Yes** ☐ **No** ☐ **Unsure** ☐ **Not Applicable**

If re-testing, has the athlete improved?
☐ **Yes** ☐ **No** ☐ **Unsure** ☐ **Not Applicable**

**I am a physician or licensed healthcare professional and I have personally administered or supervised the administration of this SCAT5.**

Signature: _____

Name: _____

Title: _____

Registration number (if applicable): _____

Date: _____

**SCORING ON THE SCAT5 SHOULD NOT BE USED AS A STAND-ALONE METHOD TO DIAGNOSE CONCUSSION, MEASURE RECOVERY OR MAKE DECISIONS ABOUT AN ATHLETE'S READINESS TO RETURN TO COMPETITION AFTER CONCUSSION.**

# Graded Symptom Scale Checklist

*Modified from various published symptom checklists*[27-30]

The Graded Symptom Scale should be used for the initial evaluation and for each subsequent follow-up assessment until all signs and symptoms have cleared at rest and during physical exertions. The athlete needs to rate each symptom according to the scale provided, '0' not having that symptom to '6' experiencing that symptom severely.

| | None | | | Moderate | | | Severe |
|---|---|---|---|---|---|---|---|
| **Score According to Severity** | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

| Symptom | Preseason Baseline | Time of Injury | 24 Hours Post-Injury | Day 3 Post-Injury | Day 4 Post-Injury | Day 5 Post-Injury |
|---|---|---|---|---|---|---|
| Blurred Vision | | | | | | |
| Dizziness | | | | | | |
| Drowsiness | | | | | | |
| Sleeping More than Usual | | | | | | |
| Easily Distracted | | | | | | |
| Fatigue | | | | | | |
| Feeling "In a Fog" | | | | | | |
| Feeling "Slowed Down" | | | | | | |
| Headache | | | | | | |
| Unusually Emotional | | | | | | |
| Irritability | | | | | | |
| Loss of Consciousness | | | | | | |
| Loss of Orientation | | | | | | |
| Memory Problems | | | | | | |
| Nauseous | | | | | | |
| Nervousness | | | | | | |
| Personality Changes | | | | | | |
| Poor Balance/Coordination | | | | | | |
| Ringing in the Ears | | | | | | |
| Sadness | | | | | | |
| Seeing Stars | | | | | | |
| Sensitivity to Light | | | | | | |
| Sensitivity to Noise | | | | | | |
| Sleep Disturbances | | | | | | |
| Vacant Stares/Glassy Eyes | | | | | | |
| Vomiting | | | | | | |
| **TOTAL SYMPTOM SCORE:** | | | | | | |

## Concussion Management Instructions

The best guideline is to note signs or symptoms that worsen and behaviors that seem to represent a change in the student-athlete. Click on the associated link to review what some of those observable signs, symptoms, and danger signs might be. If you have any question or concern about the symptoms that you are observing, contact their family physician, or seek attention at a hospital emergency room, or urgent care clinic. Otherwise, you can follow the instructions outlined below to manage concussion symptoms.

- THINGS THAT ARE OK TO DO:
  - Use acetaminophen (Tylenol®) for headaches only if directed by the physician
  - Use ice packs on head and neck as needed for comfort and relief
  - Eat light, healthy foods
  - Sleep/Rest

- THINGS THAT ARE **NOT** OK TO DO:
  - Any physical activity/sports/weightlifting until medically cleared
  - Drink alcohol
  - Drive until medically cleared
  - Take ibuprofen, aspirin, naproxen, Advil, Aleve, Motrin IB, Excedrin, or any other form of NSAIDs or sleep aids unless authorized by a physician

- UNNECESSARY ACTIONS:
  - Check eyes with a flashlight
  - Wake individual up every hour/on regular basis
  - Test reflexes
  - Stay in bed

- THINGS TO DO IN MODERATION OR RESTRICT:
  - Cell phone; tablet; computer usage
  - TV; video games
  - Loud music, especially through headphones
  - Exposure to bright or fluorescent lights

## GUIDE FOR REFERRAL TO PHYSICIAN

***WHEN IN DOUBT, REFER THE STUDENT-ATHLETE TO THE NEAREST HOSPITAL EMERGENCY DEPARTMENT, URGENT CARE CLINIC OR THE STUDENT-ATHLETE'S PERSONAL PHYSICIAN***

1. IMMEDIATE EMERGENCY REFERRAL SYMPTOMS (The student-athlete needs to be transported to the nearest ER or urgent care clinic):
    - Unequal, unreactive, or unusually dilated pupils; changes in pupil shape or size compared bilaterally
    - In and out of consciousness or complete loss of consciousness
    - A headache that gets worse and dos not go away
    - Repeated vomiting or nausea
    - Slurred speech
    - Convulsions or seizures
    - Difficulty recognizing people or places
    - Increasingly worse confusion, restlessness, or agitation
    - Unusual behavior or conversation/speech
    - Notable increase or decrease in Blood Pressure
    - Decreased or irregular respirations or pulse
    - Abnormal posturing at time of injury (decerebrate; decorticate; fencing postures)
    - Deterioration of neurologic function (Loss of sensation; difficulty moving limb; numbness; decreased coordination)
    - Any signs or symptoms related to neck or spine injuries, skull fracture, or severe bleeding

2. DAY-OF INJURY REFERRAL SYMPTOMS (If these symptoms are observed on the same day that the head injury occurred, seek medical attention.)
    - Worsening symptoms
    - Experiencing additional symptoms to what was initially reported at the time of the injury
    - Becoming symptomatic during sideline evaluation of injury or within one hour of initial/on-field evaluation

3. DELAYED REFERRAL SYMPTOMS (If these symptoms are observed the day after the injury, seek medical attention.)
    - Worsening symptoms
    - Experiencing additional symptoms to what was initially reported at the time of the injury or during sideline evaluation
    - Becoming symptomatic within 24 hours after initial injury
    - Symptoms have begun to interfere with daily activities

## CONCUSSION MANAGEMENT PHYSICIAN CLEARANCE FORM

MEMORIAL HERMANN Sports Medicine Institute

This form must be completed and signed by the student-athlete's treating physician or other appropriate healthcare professional. In accordance with H.B. 2038, this signed form must be on file with the athletic trainer, school nurse, or other designee in order to begin and complete the RTP protocol.

Student-Athlete Name:_____DOB_____Date of Concussion:_____

The above named student-athlete was referred due to having signs and/or symptoms of a Concussion. It is in my professional judgment that student-athlete may begin the RTP protocol once asymptomatic for at least 24 hours. Once the student-athlete has completed the RTP protocol, he/she is safe to return to full unrestricted sports participation.

____ Student-Athlete is **NOT CLEARED** at this time and is not allowed to participate in the RTP protocol.

Student-athlete is to return to clinic for further evaluation on: _____

____ Student-athlete is **CLEARED** to begin the required RTP Protocol under the supervision of the athletic trainer, school nurse, or designated coach. Once the student-athlete completes the protocol successfully, he/she does not need to return to treating physician and is cleared for full sports participation.

____ Student-athlete is cleared to begin the required RTP Protocol under the supervision of the athletic trainer, school nurse, or designated coach. Once the student-athlete completes the protocol successfully, he/she **MUST RETURN FOR RE-EVALUATION** before being cleared for full unrestricted sports participation.

Physician Signature: _____ Date: _____

Physician Address: _____

Physician Phone: _____ Physician Fax:_____

**STEP-WISE RETURN TO PLAY PROTOCOL (Student-athlete will only advance ONE phases per day)**

The student-athlete should be held out of all activities until asymptomatic at rest for at least_____hours **(24 hours is the minimum, though it is best practice to be asymptomatic for at least a 48 hour period) This** asymptomatic period includes mental exertion in school to help reduce the reemergence of symptoms once initiating the return to play protocol.

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

| | |
|---|---|
| **STEP 1** | Light aerobic activity (10-15 minutes); NO resistance training |
| **STEP 2** | Moderate aerobic activity (20-30 minutes); Light resistance training |
| **STEP 3** | Sport-specific, non-contact training drills (at least 30 minutes); Continue light resistance training; NO head impact activities or drills. |
| **STEP 4** | Sport-specific, light contact training drills; Progressive return to normal resistance training |
| **STEP 5** | Full contact practice but NO games or competition play |
| **STEP 6** | FULL participation in games or competition play |

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

Signature:_____ Date:_____

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

- Asymptomatic at rest and with heavy exertion (including mental exertion in school)
- Asymptomatic with light contact
- Demonstrate normal scores on cognitive assessment (e.g., ImPACT™ test, SCAT-5™) 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 student-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 student-athlete; and sport or activity in which the student-athlete participates.

**STEP-WISE PROGRESSION**:

The student-athlete will be held out of all activities until asymptomatic at rest for a required minimum 24 hour period. This asymptomatic period may include mental exertion in school to help reduce the reemergence of symptoms once initiating the RTP protocol.

**PLEASE NOTE: If any concussive symptoms occur while the student-athlete is progressing through the return to play protocol, he/she should stop all activity until asymptomatic for another 1-2 days. Once symptoms resolve, resume with the phase in which the student-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 Stage |
|---|---|---|---|
| 1 | Light Aerobic Exercise | Walking or stationary bike keeping intensity < 70% Maximum HR for 10-15 minutes. No resistance training. | Increase HR |
| 2 | Moderate Aerobic Exercise | Stationary bike, elliptical, jogging keeping intensity <85%. Maximum HR for 20-30 min. Begin 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 |
| 4 | Sport Specific, Light-Contact | Progression to more complex, light contact sport specific training drills with **NO** live opponent contact drills. Progressive return to head impact activities. Progressive return to normal resistance training. | Exercise, coordination and Cognitive load |
| 5 | Full Contact Practice | Following medical clearance, participate in normal training activities, but **NO** game or competition play. | Restore confidence & assess Functional skills by coach |
| 6 | Full Sports Participation | Return to FULL sports participation. Normal game play as tolerated. Monitor symptoms. | |

MEMORIAL HERMANN Sports Medicine Institute

# RETURN-TO-PLAY CHECK SHEET

This form is to be initialed and dated by both the student-athlete and the approved healthcare professional tasked with implementing the RTP protocol under H.B. 2038(2011). On the day following the completion of each level, the student-athlete is to be assessed by the designee in charge of the student-athlete's RTP. Student-athlete and designee will then initial and date that level to indicate that it was completed without any return in symptoms. In accordance with H.B. 2038(2011), a coach can supervise the RTP protocol, but cannot authorize a student's return to play.

The student-athlete denies any symptoms concerning a concussion. No symptoms are noted by the healthcare professional. The student-athlete is ready to proceed with the RTP Protocol.

_____ Student-athlete's Initials _____Designated Supervisor's Initials Date: _____

**STEP 1** Light aerobic activity (10-15 minutes); NO resistance training

The student-athlete denies any symptoms concerning a concussion. No symptoms are noted by the healthcare professional.

_____ Student-athlete's Initials _____Designated Supervisor's Initials Date: _____

**STEP 2** Moderate activity (20-30 minutes); LIGHT resistance training

The student-athlete denies any symptoms concerning a concussion. No symptoms are noted by the healthcare professional.

_____ Student-athlete's Initials _____Designated Supervisor's Initials Date: _____

**STEP 3** Sport-specific, non-contact drills (at least 30 minutes); Continue LIGHT resistance training; NO head impact activities or drills

The student-athlete denies any symptoms concerning a concussion. No symptoms are noted by the healthcare professional.

_____ Student-athlete's Initials _____Designated Supervisor's Initials Date: _____

**STEP 4** Sport-specific light contact training drills; Progressive return to normal resistance training

The student-athlete denies any symptoms concerning a concussion. No symptoms are noted by the healthcare professional.

_____ Student-athlete's Initials _____Designated Supervisor's Initials Date: _____

**STEP 5** Full contact practice but NO games or competition play

The student-athlete denies any symptoms concerning a concussion. No symptoms are noted by the healthcare professional.

_____ Student-athlete's Initials _____Designated Supervisor's Initials Date: _____

**STEP 6** FULL participation in games or competition play

The student-athlete denies any symptoms concerning a concussion. No symptoms are noted by the healthcare professional.

_____ Student-athlete's Initials _____Designated Supervisor's Initials Date: _____

Once all phases of the RTP Protocol is completed successfully and the student-athlete is asymptomatic, this form must be signed by the athletic trainer, school nurse or other designee and on file before the student-athlete can be allowed to return to full unrestricted sports participation.

Signature: _____ Date: _____

Printed name: (athletic trainer/ school nurse/ designated supervisor) _____

# 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)*

UTHealth The University of Texas Health Science Center at Houston | McGovern Medical School

# Return-to-Learn Process

## What It's All About:

- Students recovering from a concussion may find it very stressful to keep up with their schoolwork while not feeling well.
- A stepwise return to school and activity is best.

| | |
|---|---|
| Recovery from a concussion varies for each student. | • It is affected by factors such as<br>• Age<br>• Pre-existing conditions<br>• Prior concussions<br>• Symptom severity<br>• Course load<br>• Academic performance expectations<br>• Repeat concussions can cause different or more severe signs and symptoms. |
| The physical and cognitive symptoms of a concussion can have direct effects on learning. | Symptom → Effect<br>• Headache, dizziness → Difficulty concentrating<br>• Fatigue → Reduced processing speed<br>• Blurry or double vision → Trouble with reading & visual tasks<br>• A student should recover physically AND cognitively before returning to sport and extracurricular activities. |

## Returning to the Classroom after a Concussion:

- Being absent from school can cause a student to feel isolated, anxious, and stressed about missed learning or extracurricular opportunities, so getting the student back into the classroom is key.
- Concussed students may have memory and concentration issues that make it difficult for them to learn new material and remember information for exams.

| | |
|---|---|
| A concussed student should return to the classroom with guidance from a healthcare provider. | • A healthcare provider can develop a return-to-learn plan.<br>• The plan may include academic adjustments to help the student keep up with schoolwork while recovering from a concussion.<br>• A student should return to school when symptoms are manageable and academic adjustments can be provided. |
| An effective return-to-learn plan involves communication between the student's healthcare provider, school, and parents. | • Adjustments should be in place only when medically necessary, so the plan should be reviewed and updated each week, when a doctor's note is provided, or as symptoms improve.<br>• Parents are encouraged to contact the student's campus testing coordinator to discuss support that may be available for standardized testing (i.e., STAAR). |
| If a school cannot provide adequate academic support or if the student's symptoms prevent even a limited return to school, homebound instruction is an option. | • This may be an option when the student will be absent for an extended time (varies by school district) due to medical reasons.<br>• Homebound instruction should be used only when absolutely necessary (i.e., student has been unable to tolerate classes or half-days of school). |

Concussion Program, 6400 Fannin Street, Suite 2250, Houston, TX 77030
Tel: (713) 486-3435 | Fax: (713) 486-0897

| | Intervention | Provided for | Example of Academic Plan |
|---|---|---|---|
| Informal Plans | Academic Adjustments | Concussed students at <4 weeks post-concussion | Academic adjustments may include, but are not limited to:<br>• Shortened day<br>• Frequent breaks<br>• Sunglasses for light sensitivity<br>• Ear plugs to reduce noise sensitivity<br>• Quiet room away from others<br>• Preferential seating<br>• Shortened assignments<br>• Tutoring<br>• Postponement of exams<br>• Open-note or open-book tests<br>• Extended deadlines to complete projects and assessments<br>• Reduced brightness level on electronic device screens<br>• Audio books<br>• Pre-printed class notes |
| Formal Plans | Academic Accommodations | Students whose recovery time is greater than 3-4 weeks | 504 plan<br>• Very few concussed students will require a 504 plan.<br>• It is implemented after a comprehensive assessment by a specialist such as a school psychologist.<br>• The plan is developed by the school with guidance from the student's healthcare provider.<br>• It affords increased support and does not change the curriculum, only how the student receives educational material.<br>• Potential accommodations may include providing the student with written and verbal instructions or allowing the student to take only half of an exam.<br>• Please refer to the school district's 504 policy for additional information. |
| | Academic Modifications | Students whose recovery time is >4 weeks and may require special education services | Individual Education Plan (IEP)<br>• It is rare that concussed students will require an IEP developed by the school.<br>• Private schools are not legally obligated to abide by a 504 or IEP plan.<br>• Parents of private school children are encouraged to review their school's policies regarding potential academic support. |

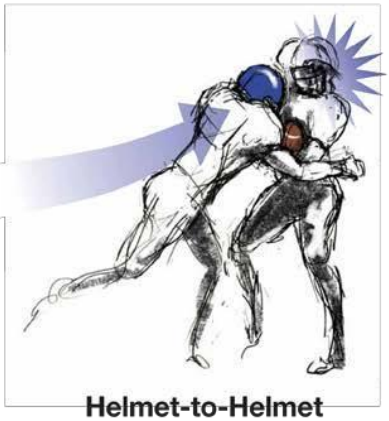
## NCAA EDUCATIONAL HANDOUTS

# PROTECT YOUR HEAD AND NECK!

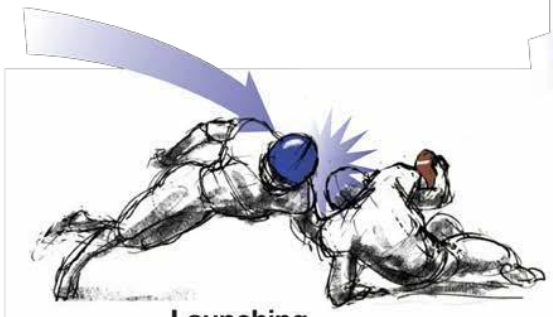
Don't punish yourself, your team, or your opponent...

Striking your opponent with your helmet can be a 15-yard penalty
and may result in serious injury to both you and your opponent!

Targeting Defenseless Opponent



Helmet-to-Helmet



Launching

Offensive *

## NCAA® 2008 Rule Changes

9-1-2-1

a) No player shall initiate contact and target an opponent with the crown of his helmet.
b) No player shall initiate contact and target a defenseless opponent
ABOVE THE SHOULDERS (i.e., whether or not with the helmet.)

*Even though rare, an offensive player can be penalized should he use his helmet to punish a player.

For more information on football rules and policies, visit NCAA.org.

**NCAA EDUCATIONAL HANDOUTS**

# FIT AND FASTEN!
## Buckle Up Completely.

### Loss of Helmet During Play.

If a player's helmet comes off during play, he must not continue to participate in the play to prevent injury. If the helmet comes off other than as the direct result of an opponent's foul, the player must also leave the game and is not allowed to participate for the next play.

- Snug, comfortable fit.
- Should not wobble, tilt or rotate when twisted.
- Check air inflation daily.
- Follow manufacturer's guidelines for fit and care.

### WARNING

Do not use this helmet to butt, ram or spear an opposing player. This is in violation of the football rules and such use can result in severe head or neck injuries, paralysis or death to you and possible injury to your opponent.

No helmet can prevent all concussions, head or any neck injuries a player might sustain while participating in football.

NCAA

## SUMMARY – TEXAS H.B. 2038 (2011) "NATASHA'S LAW"

1. The bill mandates a COT to be chosen by each school district or charter school, headed by at least one physician with concussion management training.

2. The bill defines who the healthcare professionals are that will participate in the development and implementation of the COT in schools.
    a. Physician
        i. Medical Doctor (M.D.)
        ii. Doctor of Osteopathy (D.O.)
    b. Athletic trainer
    c. Neuropsychologist
    d. Advanced practice nurse
        i. Nurse Practitioner (NP)
        ii. Nurse Anesthetist (CRNA)
        iii. Clinical Nurse Specialist (CNS)
        iv. Nurse Midwife (CNM)
    e. Physician assistant (P.A.-C.)

3. The student and the student's parent or guardian or another person with legal authority to make medical decisions for the student must have signed a form for that school year that acknowledges receiving and reading written information that explains concussion prevention, symptoms, treatment and oversight, and that includes guidelines for safely resuming participation in an athletic activity following a concussion. The form must be approved by the University Interscholastic League (UIL).

4. The bill requires students who are suspected of having sustained a concussion to be removed from the activity immediately. Those authorized to remove a student are:
    a. Coach
    b. Physician
    c. Licensed Healthcare Professional (e.g., athletic trainer, advanced practice nurse, neuropsychologist, physician assistant)
    d. Student's parent/guardian or another person with legal authority to make medical decisions for the student

5. The student suspected of sustaining a concussion must be evaluated by a physician of his or her choosing.

6. The school district must verify the student has successfully completed each requirement of the RTP protocol necessary for the student to return to play, as established by the COT.

7. The treating physician must provide a written statement indicating that, in his or her professional judgment, it is safe for the student to return to participation/competition.

8. The student and the student's parent/guardian or another person with legal authority to make medical decisions for the student acknowledges in writing:

    They have been informed concerning and consent to the student's participation in returning to play in accordance with the RTP protocol;

## SUMMARY – TEXAS H.B. 2038 (2011) "NATASHA'S LAW" (Continued)

They understand the risks associated with the student returning to play and will comply with any on-going requirements in the RTP protocol;

They consent 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 regarding the RTP recommendations of the treating physician;

They understand the immunity provisions included in H.B. 2038(2011)

9. If the school district or charter school employs an athletic trainer, he or she is responsible for the student-athlete's compliance with the RTP protocol. A coach of an interscholastic athletics team may not authorize a student's return to play.

10. The school district superintendent or the superintendent's designee or, in the case of a home-rule school district or open-enrollment charter school, the person who serves the function of superintendent or that person's designee shall supervise an athletic trainer or other person responsible for compliance with the RTP protocol. The person who has supervisory responsibilities may not be a coach of an interscholastic athletics team.

11. The bill establishes an education course for coaches. It also establishes two hours of continuing education requirements in concussion management including evaluation, prevention, symptoms, risks, and long- term effects for athletic trainers and other licensed healthcare professionals on the COT, to be taken once every two years. It is recommended that physicians serving on the COT take continuing education in concussion management.

12. The bill provides for immunity from liability for school districts or members of the COT complying with this act.

13. The bill allows the commissioner of education to develop rules as necessary to implement the bill.

14. There should be no fiscal impact in the next biennium attached to the implementation of the bill.

MEMORIAL HERMANN
Sports Medicine Institute

## FREQUENTLY ASKED QUESTIONS CONCERNING BASELINE TESTING

### What is an ImPACT™ baseline test?

ImPACT™ (Immediate Post-Concussion Assessment Cognitive Test) is a web-based, scientifically validated computerized concussion evaluation test used to test your cognitive ability. It is NOT an IQ test. It is a test of verbal and visual memory, processing speed and reaction time. It tests aspects of cognitive functioning in student-athletes with attention span, working memory, sustained and selective attention time, response variability, non-verbal problem solving and reaction time.

### How long does the test take?

Once the initial information is entered, the test usually takes approximately 20-30 minutes to complete.

### How old do I have to be to take the ImPACT™ test?

The test was designed to be taken by 10 – 59 year olds.

### How can someone obtain a cognitive baseline test if they are not in the age range for the ImPACT™ test?

There are other non-computerized neuropsychological tests that can be given to anyone younger than 10 years of age or over 59 years of age.

### What is the cost of the ImPACT™ baseline test?

The Memorial Hermann Rockets Sports Medicine Institute Concussion Program proudly offers baseline testing to school aged student-athletes at NO cost.

### What happens to the test once I have completed it?

All tests are confidential and stored on a secure server that only the Memorial Hermann Rockets Sports Medicine Institute Concussion Program neuropsychologists, physicians, and staff can access.

### Who interprets the ImPACT™ baseline results?

According to the CDC (Centers for Disease Control and Prevention) only a trained health care professional with experience in concussion management should interpret the results of any baseline or post-injury tests. When possible, ideally a neuropsychologist should interpret the computerized or paper-pencil neuropsychological test components of a baseline or post-injury exam. Results of neuropsychological tests should not be used as a stand-alone diagnostic tool, but should serve as one component used to make return to play decisions.

**FREQUENTLY ASKED QUESTIONS (Continued)**

**It has been recommended that I get a full battery of neuropsychological tests. What does this include?**

There are many tests that can be included in a full battery of neuropsychological testing. ImPACT™ may be one resource test, but usually manual paper-pencil testing is the preferred method of tests. In addition, there may be tests or questionnaires that may lean toward secondary results from a concussion such as depression, anxiety, etc.

**What if I have a concussion and go to the Emergency Room?**

Emergency Room physicians are not specifically trained to interpret ImPACT™ data and will not administer a post-injury test. You will more than likely be given a CT or MRI at the hospital. 9 times out of 10 the results are usually normal on these types of tests with general concussions, but it doesn't mean you don't have a concussion. If you have any concussion symptoms you should follow-up with a concussion specialist.

**What if I choose to see my primary doctor, can I get a copy of my ImPACT™ baseline test?**

Yes, please contact the Memorial Hermann Rockets Sports Medicine Institute Concussion Program at (713) 468-3435.

*Please note that that not all physicians are trained to interpret the ImPACT™ data and may not be able to administer a post-injury test. ImPACT™ is only one valuable resource used to test cognitive response following a concussion.*

**What if I get injured and don't have an ImPACT™ baseline?**

You would take a post-injury test and the results would be compared to the norms for your age group and gender. This gives our concussion specialist an idea of where you are supposed to be cognitively. Of course it is better to have the baseline to compare as well as follow your recovery progression.

**How often do I need to take a baseline?**

As student-athlete, we recommend you can take the baseline test as you enter the 7th grade and again upon entering the 9th and as well as when you enter college (most colleges and universities require a baseline and do the testing on their campus).

## For more information or to schedule an appointment with the Memorial Hermann Rockets Sports Medicine Institute Concussion Program, please call 713-468-3435.

Date:_____

Dear Parent/Guardian:

NCISD ISD is currently participating in an innovative program for managing sports-related concussion in conjunction with the Rockets Sports Medicine Concussion Program at Memorial Hermann. Together we are proud to provide complimentary ImPACT™ concussion baseline tests to our affiliated schools.

ImPACT™ (Immediate Post-Concussion Assessment and Cognitive Testing) is a computerized neurocognitive test that is typically used in children, adolescents, and adults who participate in sports to establish a pre-injury neurocognitive baseline. ImPACT™ is widely utilized by professional hockey, soccer, football, and baseball organizations.

It is recommended that student-athletes undergo a baseline evaluation by taking ImPACT™ in order to determine personal neurocognitive strengths and weaknesses. Essentially, the ImPACT™ test is a preseason physical of the brain, a neurocognitive baseline.

This test is taken ONLINE with provided internet access at your child's school under the close supervision of an athletic trainer and will entail assessment of memory, thinking speed, concentration and reaction time. It is not an intelligence test. ImPACT™ is set up in a "video game" type format and usually takes about 25-30 minutes to complete.

In the event a concussion should occur, your child can be re-tested and the post-concussion data compared against his/her baseline (pre-injury) data. It is strongly recommend that post-injury tests be administered under the supervision of a neuropsychologist or a concussion specialist trained in the interpretation of neurocognitive data. Based upon the post-injury evaluation, the severity of the injury and prognosis can be assessed, and then recommendations considering academic or work related accommodations can be made. It is also a valuable tool for returning student-athletes to play safely.

All test results are stored in a secure database and can be accessed by your school-based athletic trainer and affiliated Concussion Program providers.

**PROPER HEAD INJURY OR CONCUSSION FOLLOW-UP:**

If you think your child has sustained a head injury or concussion, please inform the Licensed Athletic Trainer at your school as soon as possible.

The athletic trainer can assist with coordinating post-injury assessment, evaluation and treatment with a Concussion Program provider who is specifically trained in the interpretation of neurocognitive data.

Thank you for the taking the time to consider having your child complete an ImPACT™ baseline assessment. If you have any questions or concerns regarding baseline testing, please feel free to contact your school-based athletic trainer or the Rockets Sports Medicine Institute Concussion Program at Memorial Hermann at 713.468.3535. Visit us at for more information.

Sincerely,

? Name
? Title
? School/organization
? Contact number
? Email

Memorial Hermann Rockets Sports Medicine Institute
Concussion Program
6400 Fannin, Suite 2250
Houston, TX 77030
Tel: 713.468.3435
Fax: 713.468.0897

## CONFIRMATION OF UNDERSTANDING OF LIMITED SCOPE AND PURPOSE OF BASELINE ImPACT™ TESTING

I,_____, am aware that my child (student-athlete) listed below will undergo ImPACT™ (Immediate Post-Concussion Assessment and Cognitive Testing) administered at his/her school or a Memorial Hermann Hospital System Facility under the direction of the athletic training staff and/or staff members from Memorial Hermann Sports Medicine Outreach Program or the Rockets Sports Medicine Institute Concussion Program at Memorial Hermann.

Name of student-athlete:_____ Date of Birth: _____

By signing this form, I am confirming my understanding of the following:

I understand that this test is **NOT** a comprehensive or diagnostic exam and should not take the place of routine medical care;

I understand that this is a **baseline study only**. The results of which will be stored in a secure database provided and managed by the Rockets Sports Medicine Institute Concussion Program at Memorial Hermann and may be accessed in the future in the event that my child has a concussion and I seek treatment;

I understand that my child may need additional testing and I further understand that **it is my sole responsibility to obtain such additional testing or medical care**; I understand that if it is determined that my child should need additional treatment I will be notified of any such recommendation via mail at the following current information below:

Name of Parent/Guardian (Print Clearly):_____

Street Address:_____

City, State, Zip:_____

Telephone #:_____

Email:_____

Parent/Guardian Signature:_____Date:_____

Memorial Hermann Rockets Sports Medicine Institute
Concussion Program
6400 Fannin, Suite 2250
Houston, TX 77030
Tel: 713.468.3435
Fax: 713.468.0897

MEMORIAL HERMANN Sports Medicine Institute

UTHealth | Medical School
The University of Texas Health Science Center at Houston

CONCUSSION PROGRAM

*OFFICE USE ONLY:*
Date Administered: _____
Moderator:

ImPACT™

# BASELINE TEST ADMINSTRATION WORKSHEET
# COMPLETED BY PARENT/GUARDIAN

**Select Preferred Test Language for your child:** ☐ English ☐ Spanish ☐ Other _____

**School / Organization:** _____

**Child Name:** _____

**Child Date of Birth:** _____

**Gender of Child:** ☐ Male ☐ Female

**Has your child been diagnosed with Attention Deficit Disorder or Hyperactivity?**
☐ Yes ☐ No

**Has your child been diagnosed with a Learning Disability?**
☐ Yes ☐ No

**Has your child had a concussion in the past 6 months?**
☐ Yes ☐ No

**Native Country/Region in which your child was born:** _____

**Child Native Language:** ☐ English ☐ Spanish ☐ Other _____

**Child Second Language:** ☐ English ☐ Spanish ☐ Other _____

**Years of Education your child has completed (see below):** ___ years *(do not include current year)*
(e.g., high school freshman is 8 years, high school senior is 11, and college freshman is 12)

**Check any of the following that apply to your child:**
☐ Received speech therapy
☐ Attended special education classes
☐ Repeated one or more years of school

**In school, what type of student is your child?**
☐ Below Average
☐ Average
☐ Above Average

**Child Current Sport:** _____

**Child Current Position / Event / Class:** _____

**Child Current Level of Participation:**
☐ Elementary
☐ Junior High/Middle School
☐ High School
☐ Collegiate

**Years of experience competing at this level (see below):** _____ years

*(Please approximate if uncertain and do not include current year. e.g., high school senior =3)*

## CONCUSSION HISTORY:

If your child has NO HISTORY of any past diagnosed concussions ***leave this section blank***.

If your child HAS a history of concussions, please complete the following required questions to the best of the your knowledge of their concussions.

_____ Number of times diagnosed with a concussion
_____ Total number of concussions that resulted in loss of consciousness
_____ Total number of concussions that resulted in confusion
_____ Total number of concussions that resulted in difficulty with memory for events occurring immediately ***AFTER*** injury
_____ Total number of concussions that resulted in difficulty with memory for events occurring immediately ***BEFORE*** injury
_____ Total games were missed as a direct result of all concussions combined

**Please list your child's five most recent concussions, if applicable. Use approximate dates (month and year only).**

_____ _____ _____ _____

_____

**Indicate whether your child has been treated for the following:**

☐ Yes ☐ No Headaches by physician
☐ Yes ☐ No Migraine headaches by physician
☐ Yes ☐ No Epilepsy/ seizures
☐ Yes ☐ No Brain surgery
☐ Yes ☐ No Meningitis
☐ Yes ☐ No Substance / alcohol abuse
☐ Yes ☐ No Psychiatric condition (depression, anxiety etc.)

**Has you child ever been diagnosed with any of the following conditions?**

☐ Yes ☐ No Dyslexia
☐ Yes ☐ No Autism

**Has your child participated in any strenuous exercise and/or exertion in the last three hours?**

☐ Yes ☐ No

**Date of LAST Concussion:** _____ / _____ / _____
Month Day Year

**Total hours of sleep last night:** _____ hours

**List current medications taken within the past 72 hours:**

_____

**CURRENT SYMPTOMS AND CONDITIONS:**

**Please check the box below to the degree in which your child generally experiences the following symptoms:**

*0=Not experienincg symptom 1=Barely noticeable 3=More noticeable than not 6=Severe, seeing a specialist or planning to in the future*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Headache | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Vomiting | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Nausea | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Balance problems | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Dizziness | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Trouble Falling Asleep | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Fatigue | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Sleeping too much | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Sleeping too little | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Senstivity to LIght | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Drowsiness | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Sensitivity to noise | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Irritability | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Feeling Nervous | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Sadness | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Feeling emotional | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Numbness/Tingling | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Mentally “foggy” | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Feeling too slow | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Difficulty Concentrating | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Memory Problems | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |
| Visual problems | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 | ☐ 6 |

**Memorial Hermann Healthcare System**

**Authorization for:** ■ **Disclosure** ❒ **Inspection** ❒ **Amendment**

**Of Protected Health Information**

| Patient Name | Date of Birth | SS# | MR# |
|---|---|---|---|
| | | N/A | N/A |
| Address | | | Telephone # |
| | | | ( ) |

I hereby authorize Memorial Hermann Rockets Sports Medicine Institute [6400 Fannin, Suite 1620, Houston, TX 77030]

*Facility Name*

To release information from the medical records of _____

**Patient Name**

To: _____

**Name/Address of person/organization to which disclosure is to be made**

Fax # _____ Phone # _____

For treatment dates: _____

Specify dates - this line **MUST BE** completed

For the following purpose: ❒ Medical Care ❒ Legal ❒ Insurance ■ Other (detail below)

ImPACT (Immediate Post-Concussion Assessment and Cognitive Testing) Test Results

**Select Portions**

- ❒ Abstract/Pertinent Information
- ❒ Lab
- ❒ Emergency Room
- ❒ Imaging/Radiology
- ❒ Nursing Notes
- ❒ H & P
- ❒ Cardiac Studies
- ❒ MD Progress Notes
- ❒ MD Orders
- ❒ Face Sheet
- ❒ Operative/Procedure Report

- ❒ Entire Record ***EXCLUDING*** - HIV Testing & Chemical Dependency.
- ❒ Entire Record ***INCLUDING*** - HIV Testing & Chemical Dependency.
- ❒ Entire Record ***INCLUDING*** - HIV Testing only.
- ❒ Entire Record ***INCLUDING*** - Chemical Dependency only.
- ❒ Itemized Bill
- ■ Other ImPACT Test Results

**This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above.**

I, the undersigned, have read the above and authorize the staff of Memorial Hermann Healthcare System to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

| Date | Signature of Patient/Parent/Conservator/Guardian | Authority/Relationship to |
|---|---|---|
| | | |

Fees/charges will comply with all laws and regulations applicable to release of Protected Health Information. Payment is due at time of release.

Memorial Hermann Hospital System

FOR YOUR WHOLE LIFE.™

Release of Protected Health Information

73115 11/04