CIF GRADED CONCUSSION SYMPTOM CHECKLIST

Today's Date: _____ Time: _____ Hours of Sleep: _____ Date of Diagnosis: _____

☐ Baseline Score
☐ Post Concussion Score

- Grade the 22 symptoms with a score of 0 through 6.
  - *Note that these symptoms may not all be related to a concussion.*
- You can fill this out at the beginning of the season as a baseline *(after a good night's sleep).*
- If you suffer a suspected concussion, use this checklist to record your symptoms daily.
  - *Be consistent and try to grade either at the beginning or end of each day.*
- There is no scale to compare your total score to; this checklist helps you follow your symptoms on a day-to-day basis.
  - *If your total scores are not decreasing, see your physician right away.*
- Show your baseline (if available) and daily checklists to your physician.

	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
Trouble falling asleep	0	1	2	3	4	5	6
More emotional than usual	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
TOTAL SUM OF EACH COLUMN	0						
TOTAL SYMPTOM SCORE *(Sum of all column totals)*							

NAME _____ **HIGH SCHOOL** _____

D.O.B. _____ **SPORT** _____ **PHYSICIAN (MD/DO)** _____

CIF Concussion Return to Learn (RTL) Protocol

Instructions:

- Keep brain activity below the level that causes worsening of symptoms (e.g., headache, tiredness, irritability).
- If symptoms worsen at any stage, stop activity and rest.
- Seek further medical attention if your child continues with symptoms beyond 7 days.
- If appropriate time is allowed to ensure complete brain recovery before returning to mental activity, your child may have a better outcome than if he or she tries to rush through these guidelines.
- Please give this form to teachers/school administrators to help them understand your child's recovery.

Stage	Home Activity	School Activity	Physical Activity
Brain Rest	Rest quietly, nap and sleep as much as needed. Avoid bright light if bothersome. Drink plenty of fluids and eat healthy foods every 3-4 hours. Avoid "screen time" (text, computer, cell phone, TV, video games).	No school. No homework or take-home tests. Avoid reading and studying.	Walking short distances to get around is okay. No exercise of any kind. No driving.
	This step usually ends 3-5 days after injury. Progress to the next stage when your child starts to improve, but s/he may still have some symptoms.		
Restful Home Activity	Set a regular bedtime/wake up schedule. Allow at least 8-10 hours of sleep and naps if needed. Drink lots of fluids and eat healthy foods every 3-4 hours. Limit "screen time" to less than 30 minutes a day.	No school. May begin easy tasks at home (drawing, baking, cooking). Soft music and 'books on tape' ok. Once your child can complete 60-90 minutes of light mental activity without a worsening of symptoms he/she may go to the next step.	Light physical activity, like walking. No strenuous physical activity or contact sports. No driving.
	Progress to the next stage when your child starts to improve and s/he has fewer symptoms.		
Return to School - *PARTIAL DAY*	Allow 8-10 hours of sleep per night. Avoid napping. Drink lots of fluids and eat healthy foods every 3-4 hours. "Screen time" less than 1 hour a day. Spend limited social time with friends outside of school.	Gradually return to school. Start with a few hours/half-day. Take breaks in the nurse's office or a quiet room every 2 hours or as needed. Avoid loud areas (music, band, choir, shop class, locker room, cafeteria, loud hallway and gym). Use sunglasses/ earplugs as needed. Sit in front of class. Use preprinted large font (18) class notes. Complete necessary assignments only. No tests or quizzes. Limit homework time. Multiple choice or verbal assignments better than lots of long writing. Tutoring or help as needed. Stop work if symptoms increase.	Light physical activity, like walking. No strenuous physical activity or contact sports. No driving.
	Progress to the next stage when your child can complete the above activities without symptoms.		
Return to School - *FULL DAY*	Allow 8-10 hours of sleep per night. Avoid napping. Drink lots of fluids and eat healthy foods every 3-4 hours. "Screen time" less than 1 hour a day. Spend limited social time with friends outside of school.	Progress to attending core classes for full days of school. Add in electives when tolerated. No more than 1 test or quiz per day. Give extra time or untimed homework/tests. Tutoring or help as needed. Stop work if symptoms increase.	Light physical activity, like walking. No strenuous physical activity or contact sports. No driving.
	Progress to the next stage when your child has returned to full school and is able to complete all assignments/tests without symptoms.		
Full Recovery	Return to normal home and social activities.	Return to normal school schedule and course load.	May begin and must complete the CIF Return to Play (RTP) Protocol before returning to strenuous physical activity or contact sports.

*** Guidelines adapted from Cincinnati Children's Hospital Return to Learn Protocol*

CIF Concussion Return to Play (RTP) Protocol

CA STATE LAW AB 2127 (Effective 1/1/15) STATES THAT RETURN TO PLAY (I.E., COMPETITION) CANNOT BE SOONER THAN 7 DAYS AFTER EVALUATION BY A PHYSICIAN (MD/DO) WHO HAS MADE THE DIAGNOSIS OF CONCUSSION.

Instructions:

- This *graduated return to play protocol* MUST be completed before you can return to FULL COMPETITION.
  - A certified athletic trainer (AT), physician, and/or identified concussion monitor (e.g., coach, athletic director), must monitor your progression and initial each stage after you successfully pass it.
  - Stages I to II-D take a *minimum* of 6 days to complete.
  - You must be back to normal academic activities before beginning Stage II, unless otherwise instructed by your physician.
  - You must complete one full practice *without restrictions* (Stage III) before competing in first game.
- After Stage I, you cannot progress more than one stage per day (or longer if instructed by your physician).
- If symptoms return at any stage in the progression, IMMEDIATELY STOP any physical activity and follow up with your school's AT, other identified concussion monitor, or your physician. In general, if you are symptom-free the next day, return to the previous stage where symptoms had not occurred.
- Seek further medical attention if you cannot pass a stage after 3 attempts due to concussion symptoms, or if you feel uncomfortable at anytime during the progression.

You must have written physician (MD/DO) clearance to begin and progress through the following Stages as outlined below (or as otherwise directed by physician)				
Date & Initials	Stage	Activity	Exercise Example	Objective of the Stage
	I	No physical activity for at least 2 full symptom-free days AFTER you have seen a physician	• No activities requiring exertion (weight lifting, jogging, P.E. classes)	• Recovery and elimination of symptoms
	II-A	Light aerobic activity	• 10-15 minutes *(min)* of walking or stationary biking. • Must be performed under *direct supervision* by designated individual	• Increase heart rate to no more than 50% of perceived maximum *(max)* exertion (e.g.,< 100 beats per min) • Monitor for symptom return
	II-B	Moderate aerobic activity *(Light resistance training)*	• 20-30 min jogging or stationary biking • Body weight exercises (squats, planks, push-ups), max 1 set of 10, no more than 10 min total	• Increase heart rate to 50-75% max exertion (e.g.,100-150 bpm) • Monitor for symptom return
	II-C	Strenuous aerobic activity *(Moderate resistance training)*	• 30-45 min running or stationary biking • Weight lifting ≤ 50% of max weight	• Increase heart rate to > 75% max exertion • Monitor for symptom return
	II-D	Non-contact training with sport-specific drills *(No restrictions for weightlifting)*	• Non-contact drills, sport-specific activities (cutting, jumping, sprinting) • No contact with people, padding or the floor/mat	• Add total body movement • Monitor for symptom return
Minimum of 6 days to pass Stages I and II. Prior to beginning Stage III, please make sure that written physician (MD/DO) clearance for return to play, after successful completion of Stages I and II, has been given to your school's concussion monitor				
	III	Limited contact practice	• Controlled contact drills allowed (no scrimmaging)	• Increase acceleration, deceleration and rotational forces • Restore confidence, assess readiness for return to play • Monitor for symptom return
		Full contact practice Full unrestricted practice	• Return to normal training, with contact • Return to normal unrestricted training	
MANDATORY: You must complete at least ONE contact practice before return to competition, or if non-contact sport, ONE unrestricted practice *(If contact sport, highly recommend that Stage III be divided into 2 contact practice days as outlined above)*				
	IV	Return to play (competition)	• Normal game play (competitive event)	• Return to full sports activity without restrictions

Athlete's Name: _____ Date of Concussion Diagnosis: _____

Physician (MD/DO) Recommended School Accommodations Following Concussion

Patient Name: _____ Date: _____

I, _____, give permission for my physician to share the following information with my child's school and for communication to occur between the school and my physician for changes to this plan. Parent Signature: _____

Physician Name and Contact Information: _____ Physician Signature: _____

The patient will be reevaluated for revision of these recommendations in _____ weeks. Date: _____

This patient has been diagnosed with a concussion (a brain injury) and is currently under our care. Please excuse the patient from school today due to the medical appointment. Flexibility and additional supports are needed during recovery. The following are suggestions for academic adjustments to be individualized for the student as deemed appropriate in the school setting. Adjustments can be modified as the student's symptoms improve/worsen. Please see the CIF Return to Learn Protocol for more information (cifstate.org).

Area	Requested Modifications	Comments/ Clarifications
Attendance	☐ No School ☐ Partial School day as tolerated by student – emphasis on core subject work *Encouraged Classes:* _____ *Discouraged Classes:* _____ ☐ Full School day as tolerated by student ☐ Water bottle in class/snack every 3-4 hours	
Breaks	☐ If symptoms appear/ worsen during class, allow student to go to quiet area or nurse's office; if No improvement after 30 minutes allow dismissal to home ☐ *Mandatory Breaks*: _____ ☐ Allow breaks during day as deemed necessary by student or teachers/school personnel	
Visual Stimulus	☐ Enlarged print (18 font) copies of textbook material / assignments ☐ Pre-printed notes (18 font) or note taker for class material ☐ Limited computer, TV screen, bright screen use ☐ Allow handwritten assignments (as opposed to typed on a computer) ☐ Allow student to wear sunglasses/hat in school; seat student away from windows and bright lights ☐ Reduce brightness on monitors/screens ☐ Change classroom seating to front of room as necessary	
Auditory Stimulus	☐ Avoid loud classroom activities ☐ Lunch in a quiet place with a friend ☐ Avoid loud classes/places (i.e. music, band, choir, shop class, gym and cafeteria) ☐ Allow student to wear earplugs as needed ☐ Allow class transitions before the bell	
School Work	☐ Simplify tasks (i.e. 3 step instructions) ☐ Short breaks (5 minutes) between tasks ☐ Reduce overall amount of in-class work ☐ Prorate workload (only core or important tasks) /eliminate non-essential work ☐ No homework ☐ Reduce amount of nightly homework _____ *minutes per class;* _____ *minutes maximum per night* ☐ Will attempt homework, but will stop if symptoms occur ☐ Extra tutoring/assistance requested ☐ May begin make-up of essential work	
Testing	☐ No Testing ☐ Additional time for testing/ untimed testing ☐ Alternative Testing methods: oral delivery of questions, oral response or scribe ☐ No more than one test a day ☐ No Standardized Testing	
Educational Plan	☐ Student is in need of an IEP and/or 504 Plan (for prolonged symptoms lasting >3 months, if interfering with academic performance)	
Physical Activity	☐ No physical exertion/athletics/gym/recess ☐ Walking in PE class/recess only ☐ May begin return to play following the CIF Return to Play (RTP) protocol (cifstate.org)	

Physician Letter to School

To Whom It May Concern:

Patient Name: _____ DOB: _____

INJURY STATUS	*Exam Date:* _____

__ Has been diagnosed by a MD/DO with a concussion and is under our care.
Medical follow-up evaluation is scheduled for *(date)*: _____

__ Was evaluated and did not have a concussion injury. There are no limitations on school and physical activity.

ACADEMIC ACTIVITY STATUS *(Please mark all that apply)*

__ This student is not to return to school.

__ This student may begin a return to school based on successful progression through the ***CIF Concussion Return to Learn Protocol.*** This student requires the necessary school accommodations set forth on the ***Physician (MD/DO) Recommended School Accommodations Following Concussion*** form.

__ This student is no longer experiencing any signs or symptoms of concussion and may be released to full academic participation.

Comments: _____

PHYSICAL ACTIVITY STATUS *(Please mark all that apply)*

__ This student is not to participate in physical activity of any kind.

__ This student is not to participate in recess, PE class, or other physical activities except for untimed, voluntary walking.

__ This student may begin a monitored, graduated return to play progression (per ***CIF Concussion RTP Protocol***).

__ This student is cleared for full, unrestricted athletic participation (has completed the ***CIF Concussion RTP Protocol***).

Comments: _____

Physician *(MD/DO)* Signature: _____ Date: _____

Physician Stamp and Contact Info:

Parent/Guardian Acknowledgement Signature: _____ Date: _____