Regulation

STUDENTS 7105.1

CONCUSSION MANAGEMENT PROTOCOL EXPLANATION

I. The following protocol has been established in accordance with the National Federation of State High School Associations and the International Conference on Concussion in Sport, Prague 2004.

II. The information contained below is to be used as a mere guideline to be implemented following a concussive event. The information is not to be considered as all inclusive or all encompassing.

A. When a student shows any signs or symptoms of a concussion:

1. The Student will not be allowed to return to play in the current game or practice.
2. The Student should not be left alone, and regular monitoring for deterioration is essential over the initial few hours following injury.

B. Following the initial injury, the Student must complete these steps:

1. Follow up with their primary care physical or Emergency Department within the first 24 hours (Doctor Visit One). The Student must have the initial Physical Evaluation filled out completely, signed and dated when reporting to the School Concussion Management Team (CMT) Leader.
2. Follow up with their primary care physician when asymptomatic (or a concussion specialist if there is a history of previous concussion or if post concussion symptoms last more than seven days) to be cleared to begin the Return to Play protocol (Doctor Visit Two). The Student must have the second Physician Evaluation filled out completely, signed and dated when reporting to the School CMT Leader or designee.
3. Return to play must follow a medically supervised process, including clearance by a physician (Doctor Visit Three) before step five, "Full contact training in practice setting." The Student must have the Third Doctor Visit filled out completely, signed and dated when reporting to the School CMT Leader or designee.

****Final clearance is at the discretion of the District Medical Director even if the player is cleared by another physician.****

Whitesboro Central School District
Approved by the Superintendent: 2/11/2020
Adopted: 02/01/11

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STUDENTS 7105.2

CONCUSSION CHECKLIST

Name:_____DOB:_____Grade:_____Sport:_____

Date of Injury:_____Time of Injury:_____Location of Event:_____

History

Has the athlete ever had a concussion? Yes No

(If yes, indicate date, severity and treatment received)_____

Was there a loss of consciousness? Yes No Unclear

(If yes, how long?)_____

On Site Evaluation

Description of Injury:_____

Symptoms observed at time of injury:

Dizziness	Yes	No	Headache	Yes	No
Ringing in Ears	Yes	No	Nausea/Vomiting	Yes	No
Drowsy/Sleep	Yes	No	Fatigue/Low Energy	Yes	No
"Doesn't Feel Right"	Yes	No	Feeling "Dazed"	Yes	No
Seizure	Yes	No	Poor Balance/Coord.	Yes	No
Memory Problems	Yes	No	Loss of Orientation	Yes	No
Blurred Vision	Yes	No	Sensitivity to Light	Yes	No
Vacant Stare/ Glassy Eyed	Yes	No	Sensitivity to Noise	Yes	No

***Please circle yes or no for each symptom listed above.**

Does he/she remember the injury? Yes No Unclear

Does he/she have confusion after the injury? Yes No Unclear

Other Findings/Comments:_____

Final Action Taken: Student Released to Parents / Student Sent to Hospital-Parents Notified

Evaluator's Signature:_____Title:_____

Address:_____Date:_____Phone No.:_____

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STUDENTS 7105.3

CONCUSSION PHYSICIAN EVALUATION

Name:_____

Date First Evaluation:_____ Time of Evaluation:_____

Date of Second Evaluation:_____ Time of Evaluation:_____

Symptoms Observed:	First Doctor Visit		Second Doctor Visit	
Dizziness	Yes	No	Yes	No
Headache	Yes	No	Yes	No
Tinnitus	Yes	No	Yes	No
Nausea	Yes	No	Yes	No
Fatigue	Yes	No	Yes	No
Drowsy/Sleepy	Yes	No	Yes	No
Sensitivity to Light	Yes	No	Yes	No
Anterograde Amnesia *(after impact)*	Yes	No	Yes	No
Retrograde Amnesia *(backwards in time from impact)*	Yes	No	Yes	No

***Please indicate yes or no in your respective columns. First Doctor use column 1 and second Doctor use column 2.**

First Doctor Visit:
Did the athlete sustain a concussion? (Yes or No) (one or the other must be circled)
Additional Findings/Comments:_____

_____

Recommendations/Limitations:_____

_____

Signature:_____ Date:_____

Print or stamp name:_____ Phone Number:_____

Second Doctor Visit:
*****Athlete must be completely symptom free for 72 hours (3 days) in order to begin the return to play progression.**
Please check one of the following:

☐Athlete is asymptomatic and is ready to begin the return to play progression.
☐Athlete is still symptomatic more than seven days after injury and must be referred to a concussion specialist.

Signature:_____ Date:_____

Print or stamp name:_____ Phone Number:_____

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RETURN TO PLAY PROTOCOL

Name:_____

- ✓ The cornerstone of proper concussion management is rest until all symptoms resolve and then a graded program of exertion before return to sport.
- ✓ The program is broken down into six steps in which only one step is covered per day.
- ✓ If any concussion symptoms recur, the athlete should drop back to the previous level and try to progress after 24 hours of rest.
- ✓ In addition, the student should also be monitored for recurrence of symptoms due to mental exertion, such as reading, working on a computer, or taking a test.

Date	Activity	CMT Leader Initials
_____	1. No exertion activity until asymptomatic for 72 hours (3 days).	_____
_____	2. Light aerobic exercise such as walking or stationary bike, etc. No resistance training.	_____
_____	3. Sport specific exercise such as skating, running, shooting, etc.	_____
_____	4. Non-contact training/skill drills.	_____
_____	5. Full contact training in practice setting. (medical clearance required).	_____
_____	6. Return to competition.	_____

Third Doctor Visit:
(Please check one of the following)
Athlete is ☐cleared ☐not cleared for "Full contact training in practice setting" and "Return to competition" if symptoms do not return.

Additional Findings/Comments:_____
Recommendations/Limitations:_____

Signature:_____ Date:_____
Print or stamp name:_____ Phone Number:_____

CMT Leader Follow-up: (Please check all of the following that apply)
☐Athlete has successfully completed Return to Play Protocol.
☐Doctor #2 has been contacted and updated with this information.
☐Doctor #2 has verbally cleared the athlete to return to competition.

Additional Comments:_____
_____

Signature:_____ Date:_____

Print or stamp name:_____ Date:_____

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