CONCUSSION MANAGEMENT PROTOCOL EXPLANATION

The following protocol has been established in accordance to the Concussion Management and Awareness Act (Chapter 496 of the laws of New York, 2011) and the International conference on Concussion in Sport, Zurich 2008. In addition, it has been fabricated in a collaborative effort with your District's medical and administrative staff, concussive experts in the Central New York area, the Multi-BOCES Labor Relations & Policy Office, the NYSPHSAA and Slocum Dickson Sports Medicine.

- *A student who has sustained, or is believed to have sustained, a mild traumatic brain injury (also know as concussion) must be immediately removed from participation in athletic activities.* Athletic activities, for this purpose, include competition, practices, conditioning, and any other school-sponsored athletic program. In the event there is any doubt as to whether a student has sustained a mild traumatic brain injury, it shall be presumed that the student has been so injured until proven otherwise.

- A student removed from participation in athletic activity may resume participation in athletic activity when the student completes the following steps (in order):

  a. Be evaluated by a private licensed medical provider (physician, nurse practitioner, or physician assistant within the 24 hours following the injury (Doctor Visit One). The student must have the initial Physician Evaluation filled out completely, signed and dated when reporting to the School Concussion Management Team (CMT) Leader.

  b. Be symptom free for 24 hours, without the use of medication.

  c. Follow-up and be evaluated by a licensed medical physician when asymptomatic (Doctor Visit Two) to be cleared to begin the Zurich Progressive Exertion Protocol (ZPEP). The student must have the second Physician Evaluation filled out completely, signed and dated when reporting to the School CMT Leader (assigned by the school district).

- Following successful completion of the ZPEP, the school CMT Leader (assigned by the school district) must obtain clearance from the District's medical director, or his designee, prior to the student's "return to full activities without restrictions".
- Final clearance is at the discretion of the school physician, medical director, even if the player is cleared by another (private) physician

HEAD INJURY CHECKLIST

Name:_____ Age:_____ Grade:_____ Sport:_____

Date of injury:_____ Time of injury:_____ Location of Event:_____

On Site Evaluation
Description of injury:_____

_____

_____

Is there a history of migraines or epilepsy?	Yes	No	Unclear
Was there a loss of consciousness?	Yes	No	Unclear
Does he/she remember the injury?	Yes	No	Unclear
Does he/she have confusion after the injury	Yes	No	Unclear
Has the athlete ever had a concussion?	Yes Date:_____	No	Unclear

Symptoms observed at the time of injury:

Dizziness	Yes	No	Headache	Yes	No
Ringing in Ears	Yes	No	Nausea/Vomiting	Yes	No
Drowsy/sleepy	Yes	No	Fatigue/Low Energy	Yes	No
"Don't Feel Right'	Yes	No	Feeling "Dazed"	Yes	No
Seizure	Yes	No	Poor Balance/Coordination	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

Other Findings/Comments:_____

_____

_____

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

Evaluator's Signature:_____ Title:_____

Address:_____ Date:_____ Phone No:_____

Private Provider/Emergency Room Evaluation

First Doctor Visit: Date of First Evaluation:_____

** Post dated releases will not be accepted. Please note that if there is a history of previous concussion, then referral for professional management by a specialist or concussion clinic should be strongly considered.

Symptoms Observed:

Dizziness	Yes	No	Drowsy/Sleepy	Yes	No
Headache	Yes	No	Sensitivity to Light	Yes	No
Tinnitus	Yes	No	Sensitivity to Noise	Yes	No
Nausea	Yes	No	Anterograde Amnesia	Yes	No
Fatigue	Yes	No	Retrograde Amnesia	Yes	No

** Please indicate yes or no in your respective columns.

Did the athlete sustain a concussion? (Yes or No) (one or the other must be circled)
Is there a prior history of concussion, epilepsy or migraines? Yes_____ When:_____ No_____
Additional Findings/Comments:_____
_____
_____

Signature:_____ Date:_____

Print or Stamp Name:_____ Phone Number:_____

Second Doctor Visit: Date of Second Evaluation:_____
**If athlete still has symptoms more that seven days after injury, referral to a concussion specialist/clinic should be strongly considered.

Symptoms Observed:

Dizziness	Yes	No	Drowsy/Sleepy	Yes	No
Headache	Yes	No	Sensitivity to Light	Yes	No
Tinnitus	Yes	No	Sensitivity to Noise	Yes	No
Nausea	Yes	No	Anterograde Amnesia	Yes	No
Fatigue	Yes	No	Retrograde Amnesia	Yes	No

** Please indicate yes or nor in your respective columns.

Athlete must be completely symptom free for 24 hours, without the use of medication, 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.

Additional Findings/Comments:_____

_____

Signature:_____ Date:_____

Print or Stamp Name:_____ Phone Number:_____

I agree with the above findings and the student my return to the protocol.

Parent Signature:_____ Date:_____

ZURICH PROGRESSIVE EXERTION PROTICOL

- ✓ 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 additions, 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
_____	Phase 1- Low impact, non-strenuous, light aerobic activity such as walking or riding a stationary bike. If tolerated without return of symptoms over a 24 hour period proceed to;	_____
_____	Phase 2- Higher impact, higher exertion, and moderate aerobic activity such as running or jumping rope. No resistance training. If tolerated without return of symptoms over a 24 hour period proceed to;	_____
_____	Phase 3- Sport specific non-contact activity, low resistance weight training with a spotter. If tolerated without return of symptoms over a 24 hour period proceed to;	_____
_____	Phase 4- Sport specific activity, non-contact drills. Higher resistance weight training with a spotter. If tolerated without return of symptoms over a 24 hour period proceed to;	_____
_____	Phase 5- Full contact training drills and intense aerobic activity. If tolerated without return of symptoms over a 24 hour period proceed to;	_____
_____	Phase 6- Return to full activities without restrictions.	_____

School Medical Director Release:

- ☐ Athlete has been symptom free for 24 hours
- ☐ Athlete has been evaluated by and received written authorization by a licensed physician to participate in his/her particular activity
- ☐ Athlete has successfully completed Zurich Progressive Exertion Protocol
- ☐ Athlete is cleared to participate in his/her particular activity
- ☐ Parental release/signature has been given

Additional Comments:_____

_____

Signature:_____ Date:_____

Print or Stamp Name:_____ Phone Number:_____

CMT Receipt of Release:

Signature:_____ Date:_____

Print Name:_____ Phone Number:_____