HOLLAND PATENT CENTRAL SCHOOL DISTRICT
CONCUSSION MANAGEMENT
Evaluation and Return-to-Play Protocol

The following protocol has been established in accordance to the Concussion Management 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 between the District's medical and administrative staff, concussive experts in New York State, the Multi-BOCES Labor Relations & Policy Office, the NYSPHSAA, and Slocum Dickson Medicine.

EVALUATION PROTOCOL

A student/athlete who has sustained, or is believed to have sustained a mild traumatic brain injury (also known as a concussion) must be immediately removed from participation in any athletic activities. Athletic activities, for this purpose, include competition, practicing, condition, and any other school-sponsored athletic program. In the event there is 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.

1. The athlete **will not** be allowed to return to play in the current game or practice.
2. The athlete will be **supervised continuously** and **monitored regularly** for deterioration over the initial few hours following injury.
3. A student removed from participation in athletic activity may resume participation in athletic activity when the student completes the following steps, in order:
    a. First Evaluation: The athlete **must be medically evaluated within 24 hours of the injury by a licensed medical provider (physician, nurse practitioner, or physician assistant) (First physician evaluation). The "First Physician Evaluation" must be filled out completely, signed, and dated. A copy of this evaluation must be submitted to the school nurse.**
    b. The student must be symptom free for 24-hours, without the use of medication.
    c. Second Physician Evaluation: The student must have a follow-up evaluation by a licensed medical provider when asymptomatic (Second Physician Evaluation) to begin the Zurich Progressive Exertion Protocol (ZPEP). The student **must have the second physician evaluation filled out complete, signed and dated and submitted to the school nurse.**
4. Following successful completion of the ZPEP, the school nurse must obtain clearance from the District's medical director **prior to** the students' return to full athletic participation without restrictions.

HOLLAND PATENT CENTRAL SCHOOL DISTRICT
CONCUSSION MANAGEMENT

THIS SECTION TO BE COMPLETED BY ON-SITE EVALUATOR

Student Athlete Information		
Name of Student:		
Grade:	DOB: / / Age:	Sport:
Event Location:	Date of Injury:	Time of Injury:

ON-SITE EVALUATION **Injury Information and History**			
Describe the injury and how it occurred:			
Did the student-athlete lose consciousness? ▪ If yes, for approximately how long? _____	☐ Yes	☐ No	☐ Unclear
Does the student-athlete remember being injured?	☐ Yes	☐ No	☐ Unclear
Is the student/athlete confused after the injury?	☐ Yes	☐ No	☐ Unclear
Has the student/athlete ever had a concussion before?	☐ Yes	☐ No	☐ Unclear

Symptoms Observed at the Time of the Injury					
Dizziness	☐ Yes	☐ No	Headache	☐ Yes	☐ No
Ringing in Ears	☐ Yes	☐ No	Nausea	☐ Yes	☐ No
Drowsy/Sleepy	☐ Yes	☐ No	Vomiting	☐ Yes	☐ No
"Don't Feel Right"	☐ Yes	☐ No	Feeling "Dazed"	☐ Yes	☐ No
Seizure	☐ Yes	☐ No	Poor Balance	☐ Yes	☐ No
Ringing in Ears	☐ Yes	☐ No	Poor Coordination	☐ Yes	☐ No
Memory Problems	☐ Yes	☐ No	Loss of Orientation	☐ Yes	☐ No
Blurred Vision	☐ Yes	☐ No	Sensitivity to Light	☐ Yes	☐ No
Vacant Stare	☐ Yes	☐ No	Sensitivity to Sound	☐ Yes	☐ No
Glassy Eyes	☐ Yes	☐ No	Other:		
Other Findings/Comments:					

Final Action Taken		
☐ Parents Notified ☐ Released to Parent – Signature of Parent: _____ ☐ Transported to Hospital by ☐ Parent ☐ Ambulance ☐ School Vehicle and Personnel		
Evaluator's Signature:	Title:	Date: / /
Address:	Phone:	

PAGE THREE IS TO BE COMPLETED BY EVALUATING PHYSICIANS

FIRST PHYSICIAN EVALUATION (To Be Completed within 24 Hours of the Injury)					
Date of Evaluation:			Time of Evaluation:		
Symptoms Observed at irst Physician Evaluation F					
Dizziness	☐ Yes	☐ No	Drowsy/Sleepy	☐ Yes	☐ No
Headache	☐ Yes	☐ No	Sensitivity to Sound	☐ Yes	☐ No
Tinnitus	☐ Yes	☐ No	Sensitivity to Light	☐ Yes	☐ No
Nausea	☐ Yes	☐ No	Anterograde Amnesia	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No	Retrograde Amnesia	☐ Yes	☐ No
Findings and Recommendations					
Did the student-athlete sustain a concussion? ☐ Yes ☐ No					
Additional Findings/Comments:					
What are recommendations/limitations for the student/athlete?*					
Physician's Signature:			Date:		
Print or Stamp Name:			Phone:		
*Please Note: Post-dated releases will not be accepted. Please note that is there is a history of previous concussion, the referral for professional management by a specialist or concussion clinic should be strongly considered.					

SECOND PHYSICIAN EVALUATION					
Date of Evaluation:			Time of Evaluation:		
Symptoms Observed at Second Physician Evaluation					
Dizziness	☐ Yes	☐ No	Drowsy/Sleepy	☐ Yes	☐ No
Headache	☐ Yes	☐ No	Sensitivity to Sound	☐ Yes	☐ No
Tinnitus	☐ Yes	☐ No	Sensitivity to Light	☐ Yes	☐ No
Nausea	☐ Yes	☐ No	Anterograde Amnesia	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No	Retrograde Amnesia	☐ Yes	☐ No
Other Findings/Comments:					
Findings and Recommendations					
Please check one: ☐ The student-athlete is asymptomatic and is ready to begin the return-to-play progression. ☐ The student-athlete is still symptomatic more than seven days after the injury.**					
Physician's Signature:			Date:		
Print or Stamp Name:			Phone:		
**Please Note: A student-athlete must be completely symptom-free in order to begin the return-to-play progression. If the athlete still has symptoms more than seven days after injury, referral to a concussion specialist/clinic should be strongly considered.					

ZURICH PROGRESSIVE EXERTION RETURN TO PLAY PROTOCOL
▪ The cornerstone of proper concussion management is rest until all symptoms resolve, followed by a graded program of exertion before return to play. ▪ The program is broken down into six steps, with no more than one step covered per day. ▪ If any concussion symptoms recur, the student-athlete should drop back to the previous step and try to progress through the remaining steps after 24 hours of rest. ▪ The student-athlete should also be monitored for recurrence of symptoms due to mental exertion, such as reading, working on a computer, or taking a test.

Date	Phase	Activity	Nurse Initial
	One	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 . . .	
	Two	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 . . .	
	Three	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 . . .	
	Four	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 . . .	
	Five	Full contact training drills and intense aerobic activity. If tolerated without return of symptoms over a 24-hour period, proceed to . . .	
	Six	Return to full activities without restrictions.	

SCHOOL MEDICAL DIRECTOR RELEASE	
☐ The Student/athlete has been symptom free for 24 hours.	
☐ The Student/athlete has been evaluated by and received written authorization signed by a licensed physician to participate in his/her particular activity.	
☐ The Student/athlete has successfully completed Zurich Progressive Exertion Protocol.	
☐ The Student/athlete is cleared to participate in his/her particular activity.	
Additional Comments:	
Signature:	Date:
Print or Stamp Name:	Phone: