

REGULATION

— WASHINGTON TOWNSHIP SCHOOL DISTRICT

PROGRAM

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Prevention and Treatment of Sports-Related Concussions and Head Injuries M

R 2431.4 Prevention and Treatment of Sports-Related Concussions and Head Injuries

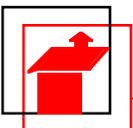
A concussion is a traumatic brain injury caused by a blow or motion to the head or body that disrupts the brain's normal functioning and can cause significant and sustained neuropsychological impairments including, but not limited to, problem-solving, planning, memory, and behavioral problems. Allowing a student to return to athletic competition or practice before recovering from a concussion increases the chance of a more serious brain injury. The following procedures shall be followed to implement N.J.S.A. 18A:40-41.1 et seq. and Policy 2431.4.

A. Athletic Head Injury Safety Training Program

1. The school district will adopt an athletic head injury safety training program.
2. The training program shall be completed by the school physician, any individual who coaches in an athletic competition, an athletic trainer involved in any athletic competition, and the school nurse.
3. This training program shall be in accordance with the guidance provided by the New Jersey Department of Education (NJDOE) and the requirements of N.J.S.A. 18A:40-41.2.

B. Prevention

1. The school district may require pre-season baseline testing of students before the student begins participation in athletic competition or practice. The baseline testing program shall be reviewed and approved by the school physician trained in evaluating and managing sports-related concussions and other head injuries.
2. The Principal or designee will review educational information for students participating in athletic competitions or practice on the prevention of concussions.
3. All school staff members, students participating in athletic competition or practice, and parents of students participating in athletic competition or



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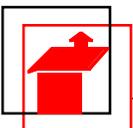
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practice shall be annually informed through the distribution of the NJDOE Concussion and Head Injury Fact Sheet and Parent/Guardian Acknowledgement Form and other communications from the principal and coaches on the importance of early identification and treatment of concussions to improve recovery.

C. Signs or Symptoms of Concussion or Other Head Injury

1. Possible signs of concussions may be observed by coaches, athletic trainers, school or team physician, school nurses, or other school staff members. Possible signs of a concussion may be, but are not limited to:
 - a. Appearing dazed, stunned, or disoriented;
 - b. Forgetting plays or demonstrating short-term memory difficulty;
 - c. Exhibiting difficulties with balance or coordination;
 - d. Answering questions slowly or inaccurately; and/or
 - e. Losing consciousness.
2. Possible symptoms of a concussion shall be reported by the student participating in athletic competition or practice to coaches, athletic trainer, school or team physician, school nurse, and/or parent. Possible symptoms of a concussion may be, but are not limited to:
 - a. Headache;
 - b. Nausea/vomiting;
 - c. Balance problems or dizziness;
 - d. Double vision or changes in vision;
 - e. Sensitivity to light or sound/noise;
 - f. Feeling sluggish or foggy;



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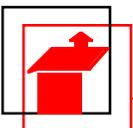
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- g. Difficulty with concentration and short-term memory;
- h. Sleep disturbance; or
- i. Irritability.

D. Medical Attention for a Student Suspected of a Concussion or Other Head Injury

1. A student who participates in athletic competition or practice and who sustains or is suspected of having sustained a concussion or other head injury while engaged in an athletic competition or practice shall be immediately removed from athletic competition or practice.
 - a. A staff member supervising the student during the athletic competition or practice shall immediately contact the school physician, athletic trainer, or school nurse to examine the student.
 - (1) The school physician, athletic trainer, or school nurse shall determine if the student has sustained or may have sustained a concussion or other head injury. The school physician, athletic trainer, or school nurse shall determine if emergency medical responders shall be called to athletic competition or practice.
 - (2) In the event the school physician, athletic trainer, or school nurse determine the student did not sustain a concussion or other head injury, the student shall not be permitted to participate in any further athletic competition or practice until written medical clearance is provided in accordance with E. below.
2. The staff member supervising a student who has been removed from athletic competition or practice in accordance with D.1. above or another staff member shall contact the student's parent and the Principal or designee as soon as possible after the student has been removed from the athletic competition or practice.



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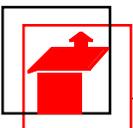
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- a. A parent shall monitor their student for symptoms of a concussion or other head injury upon receiving such notification.

E. Medical Examination and Written Medical Clearance

1. A student who was removed from athletic competition or practice in accordance with D.1. shall not participate in further athletic competition or practice until:
 - a. The student is examined by a physician or other licensed healthcare provider trained in the evaluation and management of concussions;
 - b. The student receives written medical clearance from a physician trained in the evaluation and management of concussions to return to competition or practice; and
 - c. The student returns to regular school activities and is no longer experiencing symptoms of the injury while conducting those activities.
2. The student's written medical clearance from a physician must indicate a medical examination has determined:
 - a. The student's injury was not a concussion or other head injury, the student is asymptomatic at rest, and the student may return to regular school activities and is no longer experiencing symptoms of the injury while conducting those activities; or
 - b. The student's injury was a concussion or other head injury and the student's physician will monitor the student to determine when the student is asymptomatic at rest and when the student may return to regular school activities and is no longer experiencing symptoms of the injury while conducting those activities.
3. The student's written medical clearance must be reviewed and approved by the school physician.



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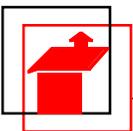
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4. The student may not begin the graduated return to athletic competition and practice protocol in F. below until the student receives a medical examination and provides the required written medical clearance.
 5. A written medical clearance not in compliance with the provisions of E. will not be accepted.
- F. Graduated Return to Athletic Competition and Practice Protocol
1. The return of a student to athletic competition and practice shall be in accordance with the graduated, six-step “Return to Play Progression” recommendations and any subsequent changes or updates to those recommendations as developed by the Centers for Disease Control and Prevention.
 - a. Back to Regular Activities (Such as School)

The student is back to their regular activities (such as school) and has the green-light from the student’s physician approved by the school physician to begin the return to play process. A student’s return to regular activities involves a stepwise process. It starts with a few days of rest (two-three days) and is followed by light activity (such as short walks) and moderate activity (such as riding a stationary bike) that do not worsen symptoms.
 - b. Light Aerobic Activity

Begin with light aerobic exercise only to increase the student’s heart rate. This means about five to ten minutes on an exercise bike, walking, or light jogging. No weightlifting at this point.
 - c. Moderate Activity

Continue with activities to increase the student’s heart rate with body or head movement. This includes moderate jogging, brief running, moderate-intensity stationary biking, and/or moderate-intensity weightlifting (less time and/or less weight from their typical routine).



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d. Heavy, Non-Contact Activity

Add heavy non-contact physical activity, such as sprinting/running, high-intensity stationary biking, regular weightlifting routine, and/or non-contact sport-specific drills (in three planes of movement).

e. Practice and Full Contact

The student may return to practice and full contact (if appropriate for the athletic competition) in controlled practice.

f. Athletic Competition

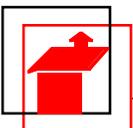
The student may return to athletic competition or practice.

2. It is important for a student's parent(s) and coach(es) to watch for concussion symptoms after each day's "Return to Play Progression" activity. A student should only move to the next step if they do not have any new symptoms at the current step.

3. If a student's symptoms return or if they develop new symptoms, this is a sign that a student is pushing too hard. The student should stop these activities and the student's health care provider should be contacted. After more rest and no concussion symptoms, a student can start at the previous step if approved by the student's healthcare provider and provides written medical clearance to the school physician.

G. Temporary Accommodations for Student's Participating in Athletic Competition with Sports-Related Head Injuries

1. The concussed brain is affected in many functional aspects as a result of the injury. Memory, attention span, concentration, and speed of processing significantly impact learning. Further, exposing the concussed student to the stimulating school environment may delay the resolution of symptoms needed for recovery. Accordingly, consideration of the cognitive effects in returning to the classroom is also an important part of the treatment of sports-related concussions and head injuries.



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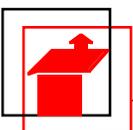
2. To recover, cognitive rest is just as important as physical rest. Reading, studying, computer usage, testing, texting, and watching movies if a student is sensitive to light/sound can slow a student's recovery. The Principal or designee may look to address the student's cognitive needs as described below. Students who return to school after a concussion may need to:
 - a. Take rest breaks as needed;
 - b. Spend fewer hours at school;
 - c. Be given more time to take tests or complete assignments (all courses should be considered);
 - d. Receive help with schoolwork;
 - e. Reduce time spent on the computer, reading, and writing; and/or
 - f. Be granted early dismissal from class to avoid crowded hallways.

Adopted: 26 July 2011

[Policy Alert 194]

Revised & Approved: 15 March 2022

[Policy Alert 226]



Sports-Related Concussion and Head Injury Fact Sheet and Parent/Guardian Acknowledgement Form

A concussion is a brain injury that can be caused by a blow to the head or body that disrupts the normal functioning of the brain. Concussions are a type of Traumatic Brain Injury (TBI), which can range from mild to severe and can disrupt the way the brain normally functions. Concussions can cause significant and sustained neuropsychological impairment affecting problem-solving, planning, memory, attention, concentration, and behavior.

The Centers for Disease Control and Prevention estimates that 300,000 concussions are sustained during sports-related activities nationwide, and more than 62,000 concussions are sustained each year in high school contact sports. The second-impact syndrome occurs when a person sustains a second concussion while still experiencing symptoms of a previous concussion. It can lead to severe impairment and even death of the victim.

Legislation (P.L. 2010, Chapter 94) signed on December 7, 2010, mandated measures to be taken in order to ensure the safety of K-12 student-athletes involved in interscholastic sports in New Jersey. It is imperative that athletes, coaches, and parents/guardians are educated about the nature and treatment of sports-related concussions and other head injuries. The legislation states that:

- All Coaches, Athletic Trainers, School Nurses, and School/Team Physicians shall complete an Interscholastic Head Injury Safety Training Program by the 2011-2012 school year.
- All school districts, charter, and non-public schools that participate in interscholastic sports will distribute annually this educational fact to all student-athletes and obtain a signed acknowledgment from each parent/guardian and student-athlete.
- Each school district, charter, and non-public school shall develop a written policy describing the prevention and treatment of sports-related concussion and other head injuries sustained by interscholastic student-athletes.
- Any student-athlete who participates in an interscholastic sports program and is suspected of sustaining a concussion will be immediately removed from competition or practice. The student-athlete will not be allowed to return to competition or practice until he/she has written clearance from a physician trained in concussion treatment and has completed his/her district's graduated return-to-play protocol.

Quick Facts

- Most concussions do not involve loss of consciousness
- You can sustain a concussion even if you do not hit your head
- A blow elsewhere on the body can transmit an "impulsive" force to the brain and cause a concussion

Signs of Concussions (Observed by Coach, Athletic Trainer, Parent/Guardian)

- Appears dazed or stunned
- Forgets plays or demonstrates short term memory difficulties (e.g. unsure of game, opponent)
- Exhibits difficulties with balance, coordination, concentration, and attention
- Answers questions slowly or inaccurately
- Demonstrates behavior or personality changes
- Is unable to recall events prior to or after the hit or fall

Symptoms of Concussion (Reported by Student-Athlete)

- Headache
- Nausea/vomiting
- Balance problems or dizziness
- Double vision or changes in vision
- Sensitivity to light/sound
- Feeling of sluggishness or fogginess
- Difficulty with concentration, short term memory, and/or confusion

What Should a Student-Athlete do if they think they have a concussion?

- **Don't hide it.** Tell your Athletic Trainer, Coach, School Nurse, or Parent/Guardian.
- **Report it.** Don't return to competition or practice with symptoms of a concussion or head injury. The sooner you report it, the sooner you may return to play.
- **Take time to recover.** If you have a concussion your brain needs time to heal. While your brain is healing you are much more likely to sustain a second concussion. Repeat concussions can cause permanent brain injury.

What can happen if a student-athlete continues to play with a concussion or returns to play too soon?

- Continuing to play with the signs and symptoms of a concussion leaves the student-athlete vulnerable to second impact syndrome.
- Second impact syndrome is when a student-athlete sustains a second concussion while still having symptoms from a previous concussion or head injury.
- Second impact syndrome can lead to severe impairment and even death in extreme cases.

Should there be any temporary academic accommodations made for Student-Athletes who have suffered a concussion?

- To recover cognitive rest is just as important as physical rest. Reading, texting, testing-even watching movies can slow down a student-athletes recovery.
- Stay home from school with minimal mental and social stimulation until all symptoms have resolved.
- Students may need to take rest breaks, spend fewer hours at school, be given extra time to complete assignments, as well as be offered other instructional strategies and classroom accommodations.

Student-Athletes who have sustained a concussion should complete a graduated return-to-play before they may resume competition or practice, according to the following protocol:

- **Step 1:** Completion of a full day of normal cognitive activities (school day, studying for tests, watching practice, interacting with peers) without reemergence of any signs or symptoms. If no return of symptoms, next day advance.
- **Step 2:** Light Aerobic exercise, which includes walking, swimming, and stationary cycling, keeping the intensity below 70% maximum heart rate. No resistance training. The objective of this step is to increase heart rate.
- **Step 3:** Sport-specific exercise including skating, and/or running: no head impact activities. The objective of this step is to add movement.
- **Step 4:** Non-contact training drills (e.g. passing drills). Student-athlete may initiate resistance training.
- **Step 5:** Following medical clearance (consultation between school health care personnel and student-athletes physician), participation in normal training activities. The objective of this step is to restore confidence and assess functional skills by coaching and medical staff.
- **Step 6:** Return to play involving normal exertion or game activity.

For further information on Sports-Related Concussions and other Head Injuries, please visit:

www.cdc.gov/concussion/sports/index.html

www.nfhs.com

www.ncaa.org/health-safety

www.bianj.org www.atsnj.org

Sports-Related Concussion and Head Injury Fact Sheet and Parent/Guardian Acknowledgement Form
(Please complete, detach, and return this form to the school's Athletic Department)

I/we have received a copy of the WTPS Sports-Related Concussion and Head Injury Fact Sheet and Parent/Guardian Acknowledgement Form and understand that I/we are responsible to read and understand its contents.

_____ Signature of Student-Athlete	_____ Print Student-Athlete's Name	_____ Date
_____ Signature of Parent/Guardian	_____ Print Parent/Guardian's Name	_____ Date

HEADS UP

CONCUSSION

IN HIGH SCHOOL SPORTS

A FACT SHEET FOR **ATHLETES**

What is a concussion?

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body.
- Can change the way your brain normally works.
- Can occur during practices or games in any sport or recreational activity.
- Can happen even if you haven't been knocked out.
- Can be serious even if you've just been "dinged" or "had your bell rung."

"All concussions are serious. A concussion can affect your ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most people with a concussion get better, but it is important to give your brain time to heal.

What are the symptoms of a concussion?

You can't see a concussion, but you might notice **one or more** of the symptoms listed below or that you "don't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

What should I do if I think I have a concussion?

- **Tell your coaches and your parents.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach right away if you think you have a concussion or if one of your teammates might have a concussion.
- **Get a medical check-up.** A doctor or other healthcare professional can tell if you have a concussion and when it is OK to return to play.
- **Give yourself time to get better.** If you have a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have another concussion. Repeat concussions can increase the time it takes for you to recover and may cause more damage to your brain. It is important to rest and not return to play until you get the OK from your health care professional that you are symptom-free.

How can I prevent a concussion?

Every sport is different, but there are steps you can take to protect yourself.

- Use the proper sports equipment, including personal protective equipment. In order for equipment to protect you, it must be:- The right equipment for the game, position, or activity- Worn correctly and the correct size and fit- Used every time you play or practice
- Follow your coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

If you think you have a concussion:

Don't hide it. Report it. Take time to recover.

It's better to miss one game than the whole season.

For more information and to order additional materials **free-of-charge**, visit: www.cdc.gov/Concussion.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

(Regulation 2431.4 Prevention/Treatment of Sports Related Concussion and Injuries)

Concussion Signs and Symptoms

Checklist

Heads Up to Schools:

**KNOW YOUR
CONCUSSION
ABCs**

Assess
the
situation

Be alert for
signs and
symptoms

Contact a
Health care
professional

Student's Name: _____ Student's Grade: _____ Date/Time of Injury: _____

Where and How Injury Occurred: (Be sure to include cause and force of the hit or blow to the head.) _____

Description of Injury: (Be sure to include information about any loss of consciousness and for how long, memory loss, or seizures following the injury, or previous concussions, if any. See the section on Danger Signs on the back of this form.) _____

DIRECTIONS:

Use this checklist to monitor students suspected of having a head injury. Students should be monitored for a minimum of 30 minutes. Check for signs or symptoms when the injury first occurred, fifteen minutes later, and at the end of 30 minutes.

Students, who experience *one or more* of the signs or symptoms of concussion after a bump, blow, or jolt to the head should be referred to a his/her physician trained in the evaluation and management of concussions.

For those instances when a parent is coming to take the student to a physician, observe the student for any new or worsening symptoms right before the student leaves. Send a copy of this checklist with the student for the physician to review.

OBSERVED SIGNS	0 MINUTES	15 MINUTES	30 MINUTES	<input type="text"/> MINUTES Just prior to leaving
Appears dazed or stunned				
Is confused about events				
Repeats questions				
Answers questions slowly				
Can't recall events <i>prior</i> to the hit, bump, or fall				
Can't recall events <i>after</i> the hit, bump, or fall				
Loses consciousness (even briefly)				
Shows behavior or personality changes				
Forgets class schedule or assignments				
PHYSICAL SYMPTOMS				
Headache or "pressure" in head				
Nausea or vomiting				
Balance problems or dizziness				
Fatigue or feeling tired				
Blurry or double vision				
Sensitivity to light				
Sensitivity to noise				
Numbness or tingling				
Does not "feel right"				
COGNITIVE SYMPTOMS				
Difficulty thinking clearly				
Difficulty concentrating				
Difficulty remembering				
Feeling more slowed down				
Feeling sluggish, hazy, foggy, or groggy				
EMOTIONAL SYMPTOMS				
Irritable				
Sad				
More emotional than usual				
Nervous				

—————> More

Danger Signs:

Be alert for symptoms that worsen over time. The student should be seen in an emergency department right away if s/he has:

- One pupil (the black part in the middle of the eye) larger than the other
- Drowsiness or cannot be awakened
- A headache that gets worse and does not go away
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Difficulty recognizing people or places
- Increasing confusion, restlessness, or agitation
- Unusual behavior
- Loss of consciousness (even a brief loss of consciousness should be taken seriously)

Additional Information About This Checklist:

This checklist is also useful if a student appears to have sustained a head injury outside of school or on a previous school day. In such cases, be sure to ask the student about possible sleep symptoms. Drowsiness, sleeping more or less than usual, or difficulty falling asleep may indicate a concussion.

To maintain confidentiality and ensure privacy, this checklist is intended only for use by appropriate school professionals, health care professionals, and the student's parent(s) or guardian(s).

For a free tear-off pad with additional copies of this form, or for more information on concussion, visit: www.cdc.gov/Concussion

SIGNATURE OF SCHOOL PROFESSIONAL COMPLETING THIS FORM: _____

TITLE: _____

Resolution of Injury:

- Student returned to class
- Student sent home
- Student referred to his/her physician who is trained in the evaluation and management of concussions

COMMENTS:

WASHINGTON TOWNSHIP PUBLIC SCHOOLS

(Prevention/Treatment of Sports-Related Concussion and Injuries, P/R 2431.4)

Medical Clearance/Release Following Student-Athlete Incident Involving Concussion Or Other Head Trauma

Name of Student: _____

Grade: _____ Phone No: _____

Name of Pupil's Physician: _____ Physician's Phone No: _____

Date of Initial Injury: _____

Description of Injury: _____

SECTION A: MEDICAL CLEARANCE/RELEASE BY STUDENT-ATHLETE'S PHYSICIAN

I certify that I am a physician trained in the evaluation and management of concussions and head injuries

(Check (✓) below as applicable):

I have examined my patient, _____ (Name of Student) on _____ (date of medical examination) and have determined that he/she is asymptomatic at rest (with no use of medications to mask headache or other symptoms) and that he/she has not sustained a concussion or other head injury and hereby release him/her to return to full athletic participation.

OR

I have examined my patient, _____ (Name of Student) on _____ (date of medical examination) and have determined that:

- He/she has sustained a concussion or other head injury.
- He/she is asymptomatic at rest (with no use of medications to mask headache or other symptoms).
- I **give** medical clearance for him/her to begin Steps 1 to 4 of the "Graduated Return to Activity, Competition, and Practice Protocol" with the following limitations or guidelines (if any):

Additional Limitations, Guidelines, and/or Information from Student Athlete's Physician:

OR

I **do not give** medical clearance for him/her to begin Steps 1 to 4 of the "Graduated Return to Activity, Competition, and Practice Protocol" at this time.

Additional Limitations, Guidelines, and/or Information from Student Athlete's Physician:

Name of Student Athlete's Physician

Signature of Student Athlete's Physician

Date

Student Athlete's Physician's Stamp

Medical Clearance/Release Following Student-Athlete Incident Involving Concussion Or Other Head Trauma (cont.)

SECTION B: SCHOOL PHYSICIAN’S REVIEW OF HOME PHYSICIAN’S CLEARANCE/MEDICAL RELEASE OF STUDENT-ATHLETE’S FOLLOWING INCIDENT OF CONCUSSION OR OTHER HEAD TRAUMA.

I have reviewed the medical clearance/release provided by the home physician of _____ (Name of Student) and; **(Check (✓) below as applicable):**

Based on the home physician’s determination that the student athlete, _____ (name of student) did not sustain a concussion or other head injury; **and**

I **concur** that the student-athlete may return to full athletic participation.

OR

I **do not give** medical clearance for the student-athlete to return to full athletic participation.

OTHER/SPECIFY

Additional Limitations, Guidelines, and/or Information from Home Physician:

Based on the home physician’s determination that the student-athlete sustained a concussion or head trauma and having reviewed the home physician’s medical clearance/release, **(Check (✓) below as applicable):**

I **concur with the student-athlete’s home physician’s** medical clearance for the student-athlete to begin Steps 1 to 4 of the “Graduated Return to Activity, Competition, and Practice Protocol” with the following limitations or guidelines:

Additional Limitations, Guidelines, and/or Information from Home Physician:

I **do not give** medical clearance for the student-athlete to return to begin Steps 1 to 4 of the “Graduated Return to Activity, Competition, and Practice Protocol” beginning on _____ (date) with the following limitations or guidelines (if any):

OTHER/SPECIFY: _____

Additional Limitations, Guidelines, and/or Information from Home Physician:

School Physician’s Name

School Physician’s Signature

Date

School Physician’s Stamp

Internal Office Use:

Date Home Physician’s Release Received: _____ Date School Physician’s Release Received: _____ Date Copy Sent to School Nurse: _____

Handling of Student-Athlete Who Sustains a Concussion

(P/R 2413.4 Concussion Testing & Return to Play)

Name of Student: _____

Grade: _____ Phone No: _____

Name of Pupil’s Physician: _____ Physician’s Phone No: _____

Date of Initial Injury: _____

Description of Injury: _____

A student-athlete who has sustained a concussion may return to full gameplay when he/she meets the following criteria:

	Completed (Yes? or No?) <u>Please Circle Below</u>	<u>Date Received</u> <u>Please List the Date Below.</u>
Submission of Medical Release/Clearance from the Student-Athlete’s Physician trained in the evaluation and management of concussion indicating that the injury was not a concussion or head injury, the student-Athlete is asymptomatic at rest (with no use of medications to mask headache or other symptoms), and the student-athlete may return to the Interscholastic Athletic activity. NOTE: The Medical Release/Clearance must be accepted/confirmed by the School Physician and reviewed by the school’s licensed Athletic Trainer or School Nurse (if licensed Athletic Trainer is not on staff). <i>Attach a copy of the medical release signed by the pupil’s physician with a sign-off by the school physician indicating his confirmation of the medical release.</i>	YES NO	Date: _____ Date Medical Release Received from Student-Athlete’s Physician Date: _____ Date Medical Release Confirmed by the School Physician Date: _____ Date Medical Release Reviewed by the School Athletic Trainer Date: _____ Date Medical Release Reviewed by the School Nurse
OR		
Submission of a Medical Release/Clearance from the Student Athlete’s Physician trained in the evaluation and management of concussion indicating that the injury was a concussion or other head injury, and that the student-athlete is asymptomatic at rest (with no use of medications to mask headache or other symptoms). and may begin the district’s “Graduated Return to Activity, Competition, and Practice Protocol”. NOTE: The Medical Release/Clearance must be accepted/confirmed by the School Physician and reviewed by the school’s licensed Athletic Trainer (or by the School Nurse in schools in which there is no licensed Athletic Trainer on staff). <i>Attach a copy of the medical release signed by the pupil’s physician with a sign-off by the school physician indicating his confirmation of the medical release.</i>	YES NO	Date: _____ Date Medical Release Received from Student-Athlete’s Physician Date: _____ Date Medical Release Confirmed by the School Physician Date: _____ Date Medical Release Reviewed by the School Athletic Trainer Date: _____ Date Medical Release Reviewed by the School Nurse
1. The student athlete must complete an individualized “Graduated Return to Activity, Competition, and Practice Protocol” outlined below which shall begin following receipt of the School Physician’s confirmation/acceptance of the Medical Release/Clearance from the Student-Athlete’s Physician including review by the Licensed Athletic Trainer (or by the School Nurse in schools in which there is no licensed athletic trainer on staff).	YES NO	Date: _____ Date “Graduated Return to Activity, Competition, and Practice Protocol” initiated?

2. Completion of the “Graduated Return to Activity, Competition, and Practice Protocol” as delineated below. *(Refer to and the complete chart below as supporting documentation.)*

YES NO Date:

 Date “Graduated Return to Activity, Competition, and Practice Protocol” Completed?

3. Verification of student-athlete’s completion of Steps 1 through 4 of the “Graduated Return to Activity, Competition, and Practice Protocol” with approval from student athlete’s physician and school physician and review of same by school athletic trainer (or by the school nurse in schools in which there is no licensed athletic trainer on staff) to undertake Steps 5 and 6 under of the “Graduated Return to Activity, Competition, and Practice Protocol.”

YES NO Date:

 Date Sections II and III A, B, C, and D of this document were completed.

4. Completion of Step 5 of the Graduated Return to Activity, Competition, and Practice Protocol” by the student-athlete without the return of symptoms.

YES NO Date:

 Date Step 5 of the “Graduated Return to Activity, Competition, and Practice Protocol” completed.

NOTE: If symptoms are experienced during or after Step 5, indicate the date and time of contact with the student-athlete’s physician. Upon approval of the Student Athlete’s Physician, the student-athlete will resume the “Graduated Return to Activity, Competition, and Practice Protocol,” dropping back to the previous step of activity where the student-athlete had no symptoms, and he/she shall try to progress again after 24 hours of rest has passed.

YES NO Date:

 Date contact made with the Student Athlete’s Physician, with receipt of further directives/approvals.

5. Completion of Step 6 of the “Graduated Return to Activity, Competition, and Practice Protocol” by the student-athlete without the return of symptoms.

YES NO Date:

 Date Step 6 of the “Graduated Return to Activity, Competition, and Practice Protocol” completed.

NOTE: If symptoms are experienced during or after Step 6, indicate the date and time of contact with the student-athlete’s physician. Upon approval of the Student Athlete’s Physician, the student-athlete will resume the “Graduated Return to Activity, Competition, and Practice Protocol,” dropping back to the previous step of activity where the student-athlete had no symptoms, and he/she shall try to progress again after 24 hours of rest has passed.

YES NO Date:

 Date contact made with the Student Athlete’s Physician, with receipt of further directives/approvals.

6. Approval of student-athlete to return to full play and participation in interscholastic sports athletic activity.

YES NO Date:

 Date or approval from Student Athlete’s physician to return to play and full participation following completion of all Steps 1 through 6 with no symptoms.

Name of Student: _____

Graduated Return to Activity, Competition, and Practice Protocol

(P 2413.4 Concussion Testing & Return to Play)

SECTION I:

The *Graduated Return-to-Activity, Competition, and Practice Protocol* is comprised of 6 steps. The 1st Phase of the Return-to-Play Protocol involves successful completion of steps 1 through step 4 of the Return-to-Play Protocol. Steps 1 through 4 are outlined below:

Each step shall be separated by twenty-four hours. If any concussion symptoms occur during the *Graduated Return-to-Activity, Competition, and Practice Protocol*, the student-athlete will be required to drop back to the previous step of activity where the student-athlete had no symptoms and try to progress again after twenty-four hours of rest has passed.

Step No.	Description of Required Activities	<u>Objective</u>	Specific Description of Assigned Activities Undertaken	Date/Time Step/Activity Started	Indication/Comments by Student-Athlete Relative to Any Symptoms Experienced/ Presented (If no symptoms/ complaints indicate as "No symptoms/ complaints")	Indications/Comments by Supervising School Athletic Trainer (If no symptoms/ complaints indicate as "No symptoms/ complaints")	Date & Time Step/Activity Completed
Step 1	<p>Completion of a full day of original cognitive activities (school day, studying for tests, watching practice, interacting with peers) without re-emergence of any signs or symptoms.</p> <p>Required 24 hour separation between steps.</p>	<u>Recovery</u>					

Student-Athlete Signature/Date

School Athletic Trainer Signature/Date

Step No.	Description of Required Activities	<u>Objective</u>	Specific Description of Assigned Activities Undertaken	Date/Time Step/Activity Started	Indication/Comments by Student-Athlete Relative to Any Symptoms Experienced/ Presented (If no symptoms/ complaints indicate as "No symptoms/ complaints")	Indications/Comments by Supervising School Athletic Trainer (If no symptoms/ complaints indicate as "No symptoms/ complaints")	Date & Time Step/Activity Completed
Step 2	<p><u>24 hours after symptom-free completion of Step 1:</u> Light aerobic exercise which includes walking, swimming, or stationary cycling keeping the intensity less than seventy percent maximum percentage heart rate and no resistance training;</p>	<u>Increase heart rate</u>					

 Student-Athlete Signature/Date

 School Athletic Trainer Signature/Date

Name of Student: _____

Step No.	Description of Required Activities	<u>Objective</u>	Specific Description of Assigned Activities Undertaken	Date/Time Step/Activity Started	Indication/Comments by Student-Athlete Relative to Any Symptoms Experienced/ Presented (If no symptoms/complaints indicate as "No symptoms/ complaints")	Indications/Comments by Supervising Coach or Athletic Trainer (If no symptoms/complaints indicate as "No symptoms/ complaints")	Date & Time Step/Activity Completed
Step 3	<p>24 Hours after symptom-free completion of Step 2: Functional exercises such as increased running intensity, agility drills, and non-contact, sport-specific drills;</p>	<p>Add movement and continue to increase heart rate.</p>					

Student-Athlete Signature/Date

School Athletic Trainer Signature/Date

Name of Student: _____

Step No.	Description of Required Activities	<u>Objective</u>	Specific Description of Assigned Activities Undertaken	Date/Time Step/Activity Started	Indication/Comments by Student-Athlete Relative to Any Symptoms Experienced/ Presented (If no symptoms/ complaints indicate as "No symptoms/ complaints")	Indications/Comments by Supervising School Athletic Trainer (If no symptoms/ complaints indicate as "No symptoms/ complaints")	Date & Time Step/Activity Completed
Step 4	<p><u>24 Hours after symptom-free completion of Step 3:</u> Non-contact practice activities and training drills involving progression to more complex training drills. Student-athlete may initiate progressive resistance training;</p>	<p>Exercise, coordination, and cognitive load</p>					

Student-Athlete Signature/Date

School Athletic Trainer Signature/Date

Section II

REVIEW AND VERIFICATION OF STUDENT-ATHLETE’S SUCCESSFUL COMPLETION OF STEPS 1 THROUGH 4 OF THE “GRADUATED ACTIVITY, COMPETITION, AND PRACTICE PROTOCOL”

Prior to undertaking Steps 5 and 6 of the *Graduated Return to Activity, Competition, and Practice Protocol*, the student-athlete returning to play, the following sections must be completed verifying that all required documentation is submitted, and the student-athlete has **completed Steps 1 through 4 of the *Graduated Return to Activity, Competition, and Practice Protocol*** without experiencing any concussion symptoms.

Note: If student-athlete experiences any concussion symptoms during the *Graduated Return to Activity, Competition, and Practice Protocol*, the student-athlete will be required to drop back to the previous step of activity where the student-athlete had no symptoms and try to progress again after 24 hours of rest has passed.

Date of Successful **Completion of Steps 1 through 4 of the *Graduated Return to Activity, Competition, and Practice Protocol***: _____.

Student: (Please print) _____ (Signature) _____ (date)

Parent/Guardian: (Please print) _____ (Signature) _____ (date)

School Athletic Trainer: (Please print) _____ (Signature) _____ (date)

School Nurse: (Please print) _____ (Signature) _____ (date)

(In Schools in which there is no licensed athletic trainer on staff)

Name of Student: _____

Section III C

School Athletic Trainer’s Review of Student-Athlete Physician’s and School Physician’s Verification of Return to Play

I have reviewed the student-athlete’s, _____ (*Name of Student*), completion of **Steps 1 through 4 of the “*Graduated Return to Activity, Competition, and Practice Protocol*”**, which has been reviewed and approved by the Student-Athlete’s home physician and the school physician.

School Athletic Trainer (Please print)

School Athletic Trainer’s Signature

Date

Section III D

School Nurse’s Review of Student-Athlete Physician’s and School Physician’s Verification of Return to Play

(Required if Licensed Athletic Trainer is not on Staff)

I have reviewed the **completion of Steps 1 through 4 of the “*Graduated Return to Activity, Competition, and Practice Protocol*”** which has been reviewed and approved by the Student-Athlete’s home physician and the school physician.

School Nurse’s Name (Please print)

School Nurse’s Signature

Date

Name of Student: _____

Section IV: Undertaking and Completion of Steps 5 and 6 of the *Graduated Return to Activity, Competition, and Practice Protocol*

Upon completion of the requirements of Sections II and Section III A, B, C, and D above, the student may undertake Steps 5 and 6 of the *Graduated Return to Activity, Competition, and Practice Protocol*. Each step shall be separated by twenty-four hours. If there is no return of any signs or symptoms of a concussion, the Student Athlete may advance to Step 6 below on the next day. If a re-emergence of any signs or symptoms of a concussion occur or if a student-athlete does not obtain medical release /clearance to proceed to Step 5, the student-athlete’s physician shall determine the student athlete’s return to competition and practice protocol in consultation with the school physician.

Step No.	Description of Required Activities	<u>Objective</u>	Specific Description of Assigned Activities Undertaken	Date/Time Step/Activity Started	Indication/Comments by Student-Athlete Relative to Any Symptoms Experienced/ Presented (If no symptoms/ complaints indicate as “No symptoms/ complaints”)	Indications/Comments by Supervising School Athletic Trainer (If no symptoms/ complaints indicate as “No symptoms/ complaints”)	Date & Time Step/Activity Completed
Step 5	<u>24 Hours after symptom-free completion of Step 4:</u> Full normal training activities following medical clearance.	Restore confidence and assess functional skills by coaching staff					

Student-Athlete Signature/Date

School Athletic Trainer Signature/Date

After 24 hours following successful symptom-free completion of Step 5 of the “*Graduated Return-to-Activity, Competition, and Practice Protocol*,” the student-athlete will undertake Step 6 of the “*Graduated Return-to-Activity, Competition, and Practice Protocol*.” If the student-athlete exhibits any concussion signs or symptoms once he/she returns to physical activity, he/she will be removed from further activities pending a consultation with the student-athlete’s physician who shall determine the appropriate course of action and the student’s athlete’s return to practice and competition protocol.

Step No.6	Description of Required Activities	<u>Objective</u>	Specific Description of Assigned Activities Undertaken	Date/Time Step/Activity Started	Indication/Comments by Student-Athlete Relative to Any Symptoms Experienced/ Presented (If no symptoms/ complaints indicate as “No symptoms/ complaints”)	Indications/Comments by Supervising School Athletic Trainer (If no symptoms/ complaints indicate as “No symptoms/ complaints”)	Date & Time Step/Activity Completed
Step 6	<u>24 Hours after symptom-free completion of Step 5:</u> Return-to-play involving normal exertion or game activity.	<u>Return-to-play</u>					

Student-Athlete Signature/Date

School Athletic Trainer Signature/Date

Name of Student: _____

Section V: REVIEW AND VERIFICATION OF STUDENT ATHLETE SUCCESSFUL COMPLETION OF ALL STEPS (INCLUDING STEPS 5 AND 6) OF THE “GRADUATED ACTIVITY, COMPETITION, AND PRACTICE PROTOCOL” -

Prior to the student-athlete returning to play, the following sections must be completed verifying that all required documentation is submitted and the student-athlete has completed **all steps (including Steps 5 and 6)** of the *Graduated Return to Activity, Competition, and Practice Protocol*.

Note: If student-athlete experiences any concussion symptoms during the *Graduated Return to Activity, Competition, and Practice Protocol*, the student-athlete will be required to drop back to the previous step of activity where the student-athlete had no symptoms and try to progress again after 24 hours of rest has passed.

Date of Successful Completion of Graduated Return to Activity, Competition, and Practice Protocol: _____

Student: (Please print) _____ (Signature) _____ (date)

Parent/Guardian: (Please print) _____ (Signature) _____ (date)

School Athletic Trainer: (Please print) _____ (Signature) _____ (date)

*School Nurse: (Please print) _____ (Signature) _____ (date)

*(In schools in which there is no licensed athletic trainer on staff.)