Newark Valley Central School District

Ryan P. Dougherty
Superintendent of School

CONCUSSION MANAGEMENT GUIDELINES FOR ATHLETIC PERFORMANCE

SIDELINE EVALUATION:

1. The Coach will monitor the athletes during practice and contests and be responsible for identifying athletes that may have sustained a concussion.
2. When a player shows any symptoms or signs of a concussion:
   a. The player will not be allowed to return to play in the current game or practice. If the Coach is unsure whether or not the athlete has suffered a concussion he/she will err on the side of caution when making a determination, *when in doubt sit them out.*
   b. A CONCUSSION CHECKLIST will be filled out by the coach, (this checklist will be forwarded to the school nurse).
   c. The player should not be left alone, and regular monitoring for deterioration is essential over the initial few hours following injury.

3. If the athlete displays deterioration then the coach will call 911 and notify the parents immediately.

4. If the athlete does not deteriorate then the coach will talk to the athlete's parents and send them home with the CONCUSSION MANAGEMENT SHEET and PHYSICIAN EVALUATION FORM. *(If the athlete is seen by a doctor, the physician evaluation form is to be filled out by the doctor and returned to the school nurse)*

RETURN TO PLAY

1. If diagnosed with a concussion, the athlete when symptom free may begin the 6 day return to play protocol.
2. When the athlete is cleared to begin activity the athlete will be progressed into full participation over the course of 6 days.

   Day 1- no exertional activity until medically cleared and asymptomatic for 24 hours.

   Day2- begins low-impact activity such as walking, stationary bike etc.

   Day 3- initiate aerobic activity fundamental to specific sport such as skating, running etc.

   Day 4 – Begin non-contact skill drills specific to sport such as dribbling, ground balls, batting etc.

   Day 5- Full contact in practice setting

   Day 6- if the athlete remains without symptoms, he or she may return to play pending release from School Health Provider.
3. If any symptoms return the athlete is to stop training immediately, rest until the following day and repeat the same workout. The athlete must progress symptom free. The Coach will complete the RETURN TO PLAY CHECKLIST and give to the school nurse when complete.
4. After completion of the return to play protocol the School Health Provider will review all paperwork and sign for athlete to return to play.
5. In the event that the athlete is seen by his or her primary care physician, the athlete must also follow the school district protocol for return to play. The athlete cannot return prior to release from his or her physician and the School Health Provider.

CONCUSSION CHECKLIST

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

Date of Injury: _____ Time of Injury: _____

On Site Evaluation

Description of injury:

_____

_____

_____

Has athlete ever had a concussion? Yes No

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

Symptoms observed at 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/Coord.	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 Noise	Yes	No

*Please circle yes or no for each symptom listed above

Other Findings/Comments: _____

_____

Final Action Taken: Parents notified Sent to Hospital

Evaluator's Signature_____ title _____

PHYSICIAN EVALUATION

Date of First Evaluation: _____ Time of Evaluation: _____
Date of Second Evaluation: _____ Time of Evaluation: _____

SYMPTOMS OBSERVED:	**1ST Doctor visit**		**2nd 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
Sensitivity to noise	Yes	No	Yes	No
Anterograde Amnesia *(after impact)*	Yes	No	N/A	N/A
Retrograde Amnesia *(Backwards in time from impact)*	Yes	No	N/A	N/A

*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 must be circled
**Post- dated releases will not be accepted. The athlete must be seen and released on the same day.
Additional
Findings/Comments_____
_____
Recommendations/Limitations/Limitations: _____
_____
Signature: _____ Date: _____

Print or stamp name: _____ Phone number: _____

Second Doctor Visit:
***Athlete must be completely symptom free in order to begin return to play protocol.
Please check one of the following:
[ ] Athlete is asymptomatic and is ready to begin return to play progression.
[ ] Athlete is still symptomatic more than seven days after injury.

Signature: _____ Date: _____

Print or stamp name: _____Phone number_____

CONCUSSION MANAGEMENT

(parent copy)

DATE: _____

Dear Parents/Guardians:

Your child _____ sustained a head injury today.

Most head injuries do not cause serious problems. However, problems related to head injury may not always occur right away. If your child develops any of the following problems you should get in touch with you health center or doctor immediately. Be sure to tell them there was a head injury and when it happened.

1. Unusual sleepiness or dizziness
2. Vomiting
3. Convulsions (seizures)
4. Clear fluid or blood draining form ears or nose (no other cold symptoms present)
5. Any trouble with vision
6. Weakness or numbness of arms or legs or trouble walking.
7. Fever and stiff neck
8. Change in behavior or confusion
9. Continued headache

The player should be medically evaluated following the injury. When your child is seen by a physician make sure you take the PHYSICIAN EVALUATION FORM with you to be filled out and returned to the school nurse.

RETURN TO PLAY CHECKLIST

Name_____

[] Concussion checklist sent to school nurse

[ ] Concussion management to parents

[ ] Accident report to school nurse

Return to play

[ ] Day 1

[ ] Day 2

[ ] Day 3

[ ] Day 4

[ ] Day 5

[ ] Day 6

The above athlete has completed the return to play protocol as indicated without any symptoms.

Coach: _____ Date _____