

IMSA Concussion Management Protocol

Compiled by the IMSA Concussion Oversight Team:

*Brian C. Kosan, ATC, NRP
Athletic Training Physician Extender
Advocate Dreyer Medical Clinics*

*Anne Joseph, MSN, RN, PEL-CSN
Head School Nurse, IMSA
Rush-Copley Hospital*

*Deepak S. Patel, MD, FAAFP, FACSM
Family & Sports Medicine Physician
Rush-Copley Medical Group*

*TBD
Head Athletic Trainer, IMSA
Athletico Physical Therapy*

*TBD
Athletic Director
Illinois Mathematics and Science Academy*

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Table of Contents

Introduction	2
Definition of a Concussion	2
Signs and Symptoms of Concussion	2
Concussion Evaluation and Classification Algorithm	3
Evaluation of Concussion	3
Concussion Severity Classification	3
Concussion Management and Treatment	4
Immediate Field Management	4
Concussion Treatment	4
Indications for Physician Referral	5
Immediate Referral Indications	5
Delayed Referral Indications	5
Return to Learn & Return to Play Criteria	5
Disqualification Timetable	6
Return to Learn	6
Return to Play Algorithm	6
Return to Play Authority and Written Authorization	7
Preseason Procedures and Policies	7
Certification and Endorsement	9
Appendix A- References	10
Appendix B- Sports Concussion Assessment Tool 3 rd Ed. (SCAT3) Form	11
Appendix C- Vestibular/Ocular Motor Screen Form	16
Appendix D- Head Injury Home Care Instructions	19
Appendix E- School Recommendations Following Concussion Form	21
Appendix F- Computerized Neuropsychological Testing Utilization Algorithm	23
Appendix G- IHSA Post Concussion Consent Form	25
Appendix H- Pre-Season Concussion Education and Acknowledgement of Risk Form	27

Introduction

The purpose of this protocol is to clearly address the issue of concussion recognition and management here at the Illinois Mathematics and Science Academy. It shall discuss the definition of a concussion, the signs and symptoms of a concussion, how the IMSA Concussion Oversight Team will evaluate and treat concussions, return to learn, return to play, and preseason procedures for students and athletes. This protocol is derived from the most recent evidence-based medical practice, the consensus and position statements from various professional medical associations, and relevant Illinois law.

Definition of a Concussion

A concussion is a complex injury process affecting the brain that is caused by a direct or indirect traumatic force on the head and/or neck, by which the brain collides with the walls of the skull. This injury process typically results in the rapid onset of short-lived impairment of neurological function. However, these impairments are generally just disturbances of brain function and not an injury to the actual structure of the nervous system. These impairments are caused by changes in blood flow to the impacted portion(s) of the brain, which decreases the amount of oxygen and nutrients available to the cells. These disturbances in brain function result in a gradually improving set of clinical symptoms which are reported by the patient and observed by others.¹⁻³

Signs and Symptoms of Concussion

Recognition of the signs and symptoms of concussion is the crux of its diagnosis and management. A symptom is something that is reported by the patient; whereas a sign is something observed by coaches, parents, or medical staff. The signs and symptoms of concussion vary from person to person and incident to incident. A concussion should be suspected if **any one or more** of the following occur in conjunction with some sort of traumatic force to the head or neck¹⁻⁴:

Symptoms Reported by Athlete	Signs Observed by Others
<ul style="list-style-type: none"> • Headache or pressure in the head • Nausea or vomiting • Dizziness • Blurred, double, or abnormal vision • Sensitivity to light and/or noise • Fatigue or “feeling slowed down” • Feeling “foggy” or “out of it” • Change in sleeping pattern • Concentration or memory issues • Confusion • Irritability • More emotional • Unusually sad, nervous, or anxious • “Just not feeling right” 	<ul style="list-style-type: none"> • Person appears dazed or stunned • Disorientation to place and/or time • Can’t recall events before injury • Can’t recall events after injury • Loss of consciousness • Seizure activity • Unusual changes in personality or mood • Nystagmus (abnormal eye tracking) • Loss of coordination • Decrease in postural stability (balance) • Slurred speech

It should be stressed that one need not lose consciousness in order to incur a concussion; rather, loss of consciousness occurs in only about 10% of cases.^{3,4} A direct blow to the head is also not necessary in

order to get a concussion. As mentioned earlier, the brain only needs to move within the cranium and collide with the walls of the skull. Therefore, an indirect force to the head like coming to a sudden stop by colliding with another person or object can cause the brain to move and create a concussion.¹⁻⁴

Concussion Evaluation and Classification Algorithm

Evaluation of Concussion

The evaluation of a concussion shall begin as soon as the medical staff makes contact with the athlete, whether that is on the field, on the sideline, or in the athletic training room. A detailed history shall first be taken in order to determine mechanism of injury, orientation, memory integrity, and a symptom inventory. A medical examination will also be conducted so as to gather vital sign and neurological baselines. Once immediate life threats are ruled out and a concussion is suspected by virtue of findings listed in the “Signs and Symptoms of Concussion” section of this protocol, the staff shall utilize the SCAT3 assessment tool (located in Appendix B) to document findings.^{1,3}

If an approved medical professional (IL licensed athletic trainer or physician) is not available to complete an evaluation of the athlete, the coaching staff must remove the athlete from competition. If there is any doubt as to whether a concussion has occurred, the coaching staff should err on the side of caution and remove the athlete from activity. Whether the competition is at home or away, they should then contact the IMSA Sports Medicine staff immediately to determine further care. As the situation dictates, the medical staff will take a history over the phone and provide the appropriate recommendations. Unless the staff directs that the athlete be taken to the hospital, the athlete shall report to the Athletic Training Office immediately upon their return to campus for a more thorough medical evaluation.

To further aid in assessing the extent of injury as well as track patient recovery, two additional specialized testing will be completed. First, the IMSA Sports Medicine Staff will utilize the Concussion Vital Signs testing software to assess more completely the patient’s cognitive function. Per the Computerized Neuropsychological Testing Utilization Algorithm (located in Appendix E), the first post-injury test on this software should be completed within 24-48 hours of incident. The test can be delayed to the 48 hour range if the patient is significantly symptomatic within the first 24 hours. Second, the Staff shall conduct the Vestibular/Ocular Motor Screen [VOMS] to assess the status of these systems.^{5,6} This screening tool (see Appendix C) should be completed in conjunction with neuropsychological testing intervals.⁵

Concussion Severity Classification

In the past, there were many systems for classification of concussion severity. Current evidence-based practice¹⁻³ has rejected the continued use of any such systems as they tend to generalize and too easily oversimplify the condition. Each incidence is to be treated as unique and each case evolves in its own way. The IMSA Sports Medicine Staff will only assign a severity grade retrospectively at the conclusion of a case for documentation purposes **only**.³ That grade will be based on the extent, severity, and duration of dysfunction.

Concussion Management and Treatment

Immediate Field Management

Concussions that do not result in the loss of consciousness will disqualify that athlete from return to play that day. They shall continue to be monitored by the medical staff through the rest of the event. The athlete's family and Resident Counselor office will be notified of the situation. The indications for referral to a physician or emergency department will be discussed with family at this time. Refer to the "Indications for Physician Referral" section of this protocol for an explanation of these indicators.¹⁻³

Concussions resulting in loss of consciousness and/or seizure activity shall be treated as a medical emergency. A high index of suspicion shall be upheld in these patients. Upon arrival to the patient's side, the cervical spine should be stabilized, evaluate for and address any immediate life threats (i.e. appropriately securing the airway), and EMS should be activated per the venue appropriate Emergency Action Plan [EAP]. These patients shall be transported to the hospital via ambulance in order to receive further medical care and evaluation.^{1,3,7} The order of adults that shall accompany the athlete to the hospital is indicated in the *IMSA General Athletics EAP*.

Concussion Treatment

At this time, there is no pharmacological or therapeutic modality that has been proven to treat concussions in the initial phase. The only initial treatment available is to get plenty of sleep, keep hydrated, and to maintain a healthy, balanced diet.^{1,3} It should be stressed that the patient should not take any pain medication like acetaminophen (Tylenol) or ibuprofen (Advil, Motrin, etc.) without consulting a physician. These medications can mask symptoms of a more serious head injury in the first 24-48 hours. Additionally, they may make other post-concussion symptoms seem to disappear before they are legitimately resolved.^{2,4}

As per school policy, if a student is suspected of having a concussion, their parents will be contacted and they shall be sent home for observation. The patient shall remain off campus until evaluated by a physician and a specific management plan is issued by this treating physician (further details in subsequent protocol sections). In the past, people were told to awaken someone with a concussion every few hours through the night. This practice is no longer recommended as it has been determined to be generally unnecessary and disrupts the sleep that is so important to recovery. The patient should be awakened at certain intervals during the night only if it is specifically recommended by an athletic trainer or ordered by a physician.^{1,3} All patients shall be sent home with a head injury home care instructions sheet.³ The sheet summarizes this section to the parents as well as provides information for monitoring the patient, and it can be located in Appendix D.

There are additional supportive therapies that can be initiated later as the patient's case progresses and **if they are deemed appropriate by the treating physician**. Controlled and supervised exercise, known as the Buffalo Protocol, has been shown to be effective for patients remaining symptomatic beyond two weeks.⁸ Studies suggest that the consumption of specific levels of Omega-3 fatty acids have anti-inflammatory characteristics that can support recovery.⁹ Patients with persistently abnormal VOMS findings can be candidates for vestibular rehabilitation and/or vision therapy.^{1,5,6}

Indications for Physician Referral

In August 2015, the Illinois General Assembly¹⁰ passed Public Act 099-0245: The Youth Sports Concussion Safety Act. This act supersedes all previous concussion laws in the state as of the beginning of the 2016 school year. It more clearly stipulates several requirements in concussion management including the necessity for direct physician involvement with each youth concussion case. Referral to a physician will occur at two different levels: immediate or delayed.

Immediate Referral Indications

The following are evaluation findings that upon which the IMSA Sports Medicine staff will strongly advise that the athlete be seen that day by a physician or in an emergency department^{3,4}:

- Loss of consciousness on the field (>1 min)
- Amnesia lasting longer than 15 minutes
- Deterioration of neurological function
- Decreasing level of consciousness
- Decrease or irregularity in respirations
- Decrease or irregularity in pulse
- Increase in blood pressure
- Unequal, dilated, or unreactive pupils
- Cranial nerve deficits
- Vomiting
- Any signs of skull or neck trauma
- Seizure activity
- Motor deficits subsequent to initial exam
- Sensory deficits subsequent to initial exam
- Balance deficits subsequent to initial exam
- New cranial nerve deficits
- Worsening post-concussion symptoms
- Appearance of symptoms not in 1st exam
- Still symptomatic at the end of the game
- Unusual personality or mood changes

Delayed Referral Indications

This is the type of physician referral that is most likely to be given. A patient should be seen by a physician experienced in the evaluation and management of concussions at the earliest possible convenience and not to exceed a span of 3 days unless the family can demonstrate extenuating circumstances (i.e. awaiting insurance approval). IMSA requires that any individual seeking physician care for a concussion complete the *School Recommendations Following Concussion* form (located in Appendix E) in order to ensure consistent, informed, and appropriate ongoing care for the patient. **A student may not return to campus until this form is completed and returned to the IMSA Health Office.**

IMSA is in the unique position of having a great deal of families with physicians and other highly qualified medical professionals as parents or relatives. The IMSA Concussion Oversight Team strenuously insists that any individual referred to a physician for a concussion evaluation should be seen by an independent physician. This position is intended to help protect all parties from ethical conflicts of interest and any possible bias. Family physicians are certainly an option for initial examination and management. Emergency department and urgent care physicians should be avoided due to the difficulty in acquiring follow-up care and orders. If specialist consultation is desired or becomes necessary due to ongoing patient issues, a list of several area concussion specialists is available.

Return to Learn & Return to Play Criteria

As discussed in the “Concussion Treatment” section of this protocol, the primary treatment is physical and cognitive rest. Concussions take time to heal, and returning to strenuous activity such as school or sport too soon can seriously hamper recovery and negatively impact academic performance. Medical evidence supports temporary academic adjustments and accommodations that progressively bring a student back to full academic participation based on findings from a comprehensive, multimodal

medical approach.^{1,11-15} A progressive return to physical [RTP] activity and athletic competition has existed for several years already and continues to be a standard of practice as well as Illinois law.^{1,3,10}

Disqualification Timetable

It is with these considerations in mind that the athlete can only return to learning and play once certain milestones and indicators are met. As mentioned in the “Immediate Field Management” section, an IMSA athlete ***will never*** be returned to practice or competition that day if a concussion is suspected. The athlete will remain disqualified from competition until cleared by a physician and there is satisfactory completion of return to learn as well as return to play procedures.¹⁰ Most adults (80-90%) will recover cognitively within 7-14 days, but adolescents can sometimes take longer than adults due to the still developing state of the brain. Recovery will also potentially take longer in those with learning disabilities (such as dyslexia or ADD/ADHD) and/or psychiatric conditions (such as depression).^{1,3,15} As discussed, current research supports a multimodal approach to assessment and management of concussions. These approaches now indicate that a typical recovery is now considered to be in the range of 21 to 28 days.¹⁵

Disqualification tables such as those proposed by Cantu¹⁶ are no longer considered valid due to their rigid adherence to set limits and classifications. An appropriately trained physician shall guide all decisions regarding the termination of a season or career.^{1-4,16}

Return to Learn

When a student is examined by a physician for a concussion, the doctor will fill out the *School Recommendation Following Concussion Form* (see Appendix E). This form (or other written physician order) needs to be filed with the IMSA Health Office prior to the student’s return to campus. The school nurse will manage the return to learn [RTL] progression and disseminate the ordered adjustments and accommodations to the appropriate personnel in the offices of the Principal, College and Academic Counseling, and Student Life. Academic adjustments will be based on the patient’s clinical presentation, and they can include (but are not limited to) extra time for tests, extensions on assignments, study limits, and screen exposure limits.¹¹⁻¹⁴ The school nurse can modify the suggested accommodations to support day-to-day needs of the recovering student, but significant changes or failure to progress through the stages will require further consultation with the treating physician and/or the rest of the IMSA Concussion Oversight Team. The individual stages of the return to learn sequence are listed in Appendix E.

Return to Play Algorithm

Once the athlete is asymptomatic at rest, has normal cognition, and completed the return to learn sequence they shall be allowed to progressively work back to competition. If physician authorization to begin return to play was not already provided during the return to learn phase, it will be required for the Sports Medicine Staff to begin return to play. There is a step-wise manner in which they must progress, and at least a 24-hour period must elapse before moving to the next stage. The athlete may not move on to the next stage unless they demonstrate acceptable ability at the current stage. Any recurrence of symptoms means that the sequence must be restarted. Appropriate assessment shall be done before and after each stage in the return to play progression in order to check for subtle symptom recurrence. The stages of progression are as follows¹⁻³:

Stage	Functional Exercise	Stage Objective
1. No Activity	Complete physical & mental rest	Recovery
2. Light Aerobic exercise	Walking, swimming, stationary bike @ <70% of max heart rate; No resistance training	Increase heart rate and test exertion in a controlled environment
3. Sport-Specific exercise	Running, shooting, or hitting drills	Add movement with exertion
4. Non-contact training drills	Progression to more complex training drills; may start progressive resistance training	Exercise, coordination, and cognitive load
5. Full-contact practice	Following medical clearance, return to normal training activities	Restore athlete's confidence; coaching staff assesses functional skills
6. Return to play	Normal game play	

Return to Play Authority and Written Authorization

Illinois Public Act 099-0245 vests same day return to play authority solely with physicians “licensed to practice medicine in all of its branches under the Medical Practice Act of 1987” and licensed athletic trainers “under supervision of physician.”¹⁰ Otherwise, return to learn and return to play authority comes only from a physician as defined by Illinois law.

Prior to the beginning of RTL/RTP, in addition to receipt of physician authorization and direction, the parent(s)/guardian(s) as well as the student must complete the IHSA Post-Concussion Consent Form (located in Appendix G). This form serves two purposes: allow the parties involved to provide informed consent for the respective processes as well as a means for formal documentation of completion of these sequences. An athlete cannot return to play until the school nurse, athletic trainer, and athletic director's signatures are affixed to this document. The completed form will remain on file in the IMSA Health Office.

The IMSA Concussion Oversight Team will be the final arbiters on RTL/RTP decisions. They can request further clarification from an outside physician and/or restrict the progression of the student if additional concerns arise.

Preseason Procedures and Policies

At the start of each sports season, each student participating in IHSA sports must ensure a signed (within last year) risk awareness form is on file with the Student Life Office as required by law.¹⁰ This form will educate both parents and athletes as to the risks of concussion as well as signs and symptoms of a concussion. The form can be found in Appendix H of this protocol. In addition to this awareness form, sophomore and senior students will undergo baseline neurocognitive testing, and those participating in high risk sports, baseline balance testing as well. This data will be used for comparison in order to establish return to normal in the event of an incident. At this time, there is no consensus as to how often baseline testing should occur.¹⁻³ Until consensus is reached, baseline testing will be considered valid for two years unless there is a change in the student's medical history (i.e. diagnosis of a concussion, learning disability, migraines, or psychiatric condition).

All IMSA coaches must complete the required training on concussions as prescribed by Illinois law, and record of successful completion must be on file with the Athletic Director. They must also acknowledge their awareness of the locations of the posted Concussion Emergency Action Plans as well as their agreement to abide this protocol. The individual members of the IMSA Concussion Oversight Team must have copies of the required annual concussion-related, evidence-based continuing education courses from their respective governing bodies on file. These records shall be maintained in the IMSA Athletic Office.

2016-2017

Certification and Endorsement

This protocol has been complied to conform to the most recent evidence-based medical practice, the standards as set forth by our professions, and Illinois state law. The directives contained therein will be adhered to by the members of the IMSA Concussion Oversight Team as delineated by Illinois Law. Deviation for this protocol shall occur only upon written orders by a physician. This protocol will undergo an annual review, and it shall be revised as needed during that review.


X

Dr. Deepak S. Patel, MD, FAAFP, FACSM
IMSA Concussion Oversight Team Physician

X

Anne Joseph, MSN, RN, PEL-CSN
Head School Nurse, IMSA

X

Brian C. Kosan, ATC, NRP
Concussion Oversight Team Consultant

X

Head Athletic Trainer, IMSA

X

Athletic Director, IMSA



Appendix A- References

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Appendix B- Sports Concussion Assessment Tool 3rd Ed. (SCAT3) Form

SCAT3™



Sport Concussion Assessment Tool – 3rd Edition

For use by medical professionals only

Name

Date/Time of Injury:
Date of Assessment:

Examiner:

What is the SCAT3?¹

The SCAT3 is a standardized tool for evaluating injured athletes for concussion and can be used in athletes aged from 13 years and older. It supersedes the original SCAT and the SCAT2 published in 2005 and 2009, respectively². For younger persons, ages 12 and under, please use the Child SCAT3. The SCAT3 is designed for use by medical professionals. If you are not qualified, please use the Sport Concussion Recognition Tool¹. Preseason baseline testing with the SCAT3 can be helpful for interpreting post-injury test scores.

Specific instructions for use of the SCAT3 are provided on page 3. If you are not familiar with the SCAT3, please read through these instructions carefully. This tool may be freely copied in its current form for distribution to individuals, teams, groups and organizations. Any revision or any reproduction in a digital form requires approval by the Concussion in Sport Group.

NOTE: The diagnosis of a concussion is a clinical judgment, ideally made by a medical professional. The SCAT3 should not be used solely to make, or exclude, the diagnosis of concussion in the absence of clinical judgement. An athlete may have a concussion even if their SCAT3 is "normal".

What is a concussion?

A concussion is a disturbance in brain function caused by a direct or indirect force to the head. It results in a variety of non-specific signs and/or symptoms (some examples listed below) and most often does not involve loss of consciousness. Concussion should be suspected in the presence of **any one or more** of the following:

- Symptoms (e.g., headache), or
- Physical signs (e.g., unsteadiness), or
- Impaired brain function (e.g. confusion) or
- Abnormal behaviour (e.g., change in personality).

SIDELINE ASSESSMENT

Indications for Emergency Management

NOTE: A hit to the head can sometimes be associated with a more serious brain injury. Any of the following warrants consideration of activating emergency procedures and urgent transportation to the nearest hospital:

- Glasgow Coma score less than 15
- Deteriorating mental status
- Potential spinal injury
- Progressive, worsening symptoms or new neurologic signs

Potential signs of concussion?

If any of the following signs are observed after a direct or indirect blow to the head, the athlete should stop participation, be evaluated by a medical professional and **should not be permitted to return to sport the same day** if a concussion is suspected.

Any loss of consciousness?	<input type="checkbox"/> Y <input type="checkbox"/> N
"If so, how long?" _____	
Balance or motor incoordination (stumbles, slow/laboured movements, etc.)?	<input type="checkbox"/> Y <input type="checkbox"/> N
Disorientation or confusion (inability to respond appropriately to questions)?	<input type="checkbox"/> Y <input type="checkbox"/> N
Loss of memory:	<input type="checkbox"/> Y <input type="checkbox"/> N
"If so, how long?" _____	
"Before or after the injury?" _____	
Blank or vacant look:	<input type="checkbox"/> Y <input type="checkbox"/> N
Visible facial injury in combination with any of the above:	<input type="checkbox"/> Y <input type="checkbox"/> N

1 Glasgow coma scale (GCS)

Best eye response (E)

No eye opening	1
Eye opening in response to pain	2
Eye opening to speech	3
Eyes opening spontaneously	4

Best verbal response (V)

No verbal response	1
Incomprehensible sounds	2
Inappropriate words	3
Confused	4
Oriented	5

Best motor response (M)

No motor response	1
Extension to pain	2
Abnormal flexion to pain	3
Flexion/Withdrawal to pain	4
Localizes to pain	5
Obeys commands	6

Glasgow Coma score (E + V + M)	of 15
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GCS should be recorded for all athletes in case of subsequent deterioration.

2 Maddocks Score³

"I am going to ask you a few questions, please listen carefully and give your best effort."

Modified Maddocks questions (1 point for each correct answer)

What venue are we at today?	0	1
Which half is it now?	0	1
Who scored last in this match?	0	1
What team did you play last week/game?	0	1
Did your team win the last game?	0	1

Maddocks score	of 5
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Maddocks score is validated for sideline diagnosis of concussion only and is not used for serial testing.

Notes: Mechanism of Injury ("tell me what happened?"):

Any athlete with a suspected concussion should be REMOVED FROM PLAY, medically assessed, monitored for deterioration (i.e., should not be left alone) and should not drive a motor vehicle until cleared to do so by a medical professional. No athlete diagnosed with concussion should be returned to sports participation on the day of injury.

BACKGROUND

Name: _____ Date: _____
 Examiner: _____
 Sport/team/school: _____ Date/time of injury: _____
 Age: _____ Gender: ☐ M ☐ F
 Years of education completed: _____
 Dominant hand: ☐ right ☐ left ☐ neither
 How many concussions do you think you have had in the past? _____
 When was the most recent concussion? _____
 How long was your recovery from the most recent concussion? _____
 Have you ever been hospitalized or had medical imaging done for a head injury? ☐ Y ☐ N
 Have you ever been diagnosed with headaches or migraines? ☐ Y ☐ N
 Do you have a learning disability, dyslexia, ADD/ADHD? ☐ Y ☐ N
 Have you ever been diagnosed with depression, anxiety or other psychiatric disorder? ☐ Y ☐ N
 Has anyone in your family ever been diagnosed with any of these problems? ☐ Y ☐ N
 Are you on any medications? If yes, please list: ☐ Y ☐ N

SCAT3 to be done in resting state. Best done 10 or more minutes post exercise.

SYMPTOM EVALUATION

3 How do you feel?

"You should score yourself on the following symptoms, based on how you feel now".

	none	mild		moderate		severe	
Headache	0	1	2	3	4	5	6
“Pressure in head”	0	1	2	3	4	5	6
Neck Pain	0	1	2	3	4	5	6
Nausea or vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred vision	0	1	2	3	4	5	6
Balance problems	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like “in a fog”	0	1	2	3	4	5	6
“Don’t feel right”	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6
Difficulty remembering	0	1	2	3	4	5	6
Fatigue or low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
More emotional	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or Anxious	0	1	2	3	4	5	6

Total number of symptoms (Maximum possible 22) _____

Symptom severity score (Maximum possible 132) _____

Do the symptoms get worse with physical activity? ☐ Y ☐ N

Do the symptoms get worse with mental activity? ☐ Y ☐ N

☐ self rated ☐ self rated and clinician monitored

☐ clinician interview ☐ self rated with parent input

Overall rating: If you know the athlete well prior to the injury, how different is the athlete acting compared to his/her usual self?

Please circle one response:

☐ no different ☐ very different ☐ unsure ☐ N/A

Scoring on the SCAT3 should not be used as a stand-alone method to diagnose concussion, measure recovery or make decisions about an athlete's readiness to return to competition after concussion. Since signs and symptoms may evolve over time, it is important to consider repeat evaluation in the acute assessment of concussion.

COGNITIVE & PHYSICAL EVALUATION

4 Cognitive assessment

Standardized Assessment of Concussion (SAC)⁴

Orientation (1 point for each correct answer)

What month is it?	0	1
What is the date today?	0	1
What is the day of the week?	0	1
What year is it?	0	1
What time is it right now? (within 1 hour)	0	1

Orientation score _____ of 5

Immediate memory

List	Trial 1	Trial 2	Trial 3	Alternative word list
elbow	0 1	0 1	0 1	candle baby finger
apple	0 1	0 1	0 1	paper monkey penny
carpet	0 1	0 1	0 1	sugar perfume blanket
saddle	0 1	0 1	0 1	sandwich sunset lemon
bubble	0 1	0 1	0 1	wagon iron insect
Total				

Immediate memory score total _____ of 15

Concentration: Digits Backward

List	Trial 1	Alternative digit list
4-9-3	0 1	6-2-9 5-2-6 4-1-5
3-8-1-4	0 1	3-2-7-9 1-7-9-5 4-9-6-8
6-2-9-7-1	0 1	1-5-2-8-6 3-8-5-2-7 6-1-8-4-3
7-1-8-4-6-2	0 1	5-3-9-1-4-8 8-3-1-9-6-4 7-2-4-8-5-6
Total of 4		

Concentration: Month in Reverse Order (1 pt. for entire sequence correct)

Dec-Nov-Oct-Sept-Aug-Jul-Jun-May-Apr-Mar-Feb-Jan 0 1

Concentration score _____ of 5

5 Neck Examination:

Range of motion Tenderness Upper and lower limb sensation & strength

Findings: _____

6 Balance examination

Do one or both of the following tests.

Footwear (shoes, barefoot, braces, tape, etc.) _____

Modified Balance Error Scoring System (BESS) testing⁵

Which foot was tested (i.e. which is the non-dominant foot) ☐ Left ☐ Right

Testing surface (hard floor, field, etc.) _____

Condition

Double leg stance: _____ Errors

Single leg stance (non-dominant foot): _____ Errors

Tandem stance (non-dominant foot at back): _____ Errors

And / Or

Tandem gait^{6,7}

Time (best of 4 trials): _____ seconds

7 Coordination examination

Upper limb coordination

Which arm was tested: ☐ Left ☐ Right

Coordination score _____ of 1

8 SAC Delayed Recall⁴

Delayed recall score _____ of 5

INSTRUCTIONS

Words in *Italics* throughout the SCAT3 are the instructions given to the athlete by the tester.

Symptom Scale

"You should score yourself on the following symptoms, based on how you feel now".

To be completed by the athlete. In situations where the symptom scale is being completed after exercise, it should still be done in a resting state, at least 10 minutes post exercise.

For total number of symptoms, maximum possible is 22.

For Symptom severity score, add all scores in table, maximum possible is 22 x 6 = 132.

SAC⁴

Immediate Memory

"I am going to test your memory. I will read you a list of words and when I am done, repeat back as many words as you can remember, in any order."

Trials 2 & 3:

"I am going to repeat the same list again. Repeat back as many words as you can remember in any order, even if you said the word before."

Complete all 3 trials regardless of score on trial 1 & 2. Read the words at a rate of one per second.

Score 1 pt. for each correct response. Total score equals sum across all 3 trials. Do not inform the athlete that delayed recall will be tested.

Concentration

Digits backward

"I am now going to read you a string of numbers and when I am done, you repeat them back to me backwards, in reverse order of how I read them to you. For example, if I say 7-1-9, you would say 9-1-7."

If correct, go to next string length. If incorrect, read trial 2. **One point possible for each string length.** Stop after incorrect on both trials. The digits should be read at the rate of one per second.

Months in reverse order

"Now tell me the months of the year in reverse order. Start with the last month and go backward. So you'll say December, November ... Go ahead"

1 pt. for entire sequence correct

Delayed Recall

The delayed recall should be performed after completion of the Balance and Coordination Examination.

"Do you remember that list of words I read a few times earlier? Tell me as many words from the list as you can remember in any order."

Score 1 pt. for each correct response

Balance Examination

Modified Balance Error Scoring System (BESS) testing⁵

This balance testing is based on a modified version of the Balance Error Scoring System (BESS)⁵. A stopwatch or watch with a second hand is required for this testing.

"I am now going to test your balance. Please take your shoes off, roll up your pant legs above ankle (if applicable), and remove any ankle taping (if applicable). This test will consist of three twenty second tests with different stances."

(a) Double leg stance:

"The first stance is standing with your feet together with your hands on your hips and with your eyes closed. You should try to maintain stability in that position for 20 seconds. I will be counting the number of times you move out of this position. I will start timing when you are set and have closed your eyes."

(b) Single leg stance:

"If you were to kick a ball, which foot would you use? [This will be the dominant foot] Now stand on your non-dominant foot. The dominant leg should be held in approximately 30 degrees of hip flexion and 45 degrees of knee flexion. Again, you should try to maintain stability for 20 seconds with your hands on your hips and your eyes closed. I will be counting the number of times you move out of this position. If you stumble out of this position, open your eyes and return to the start position and continue balancing. I will start timing when you are set and have closed your eyes."

(c) Tandem stance:

"Now stand heel-to-toe with your non-dominant foot in back. Your weight should be evenly distributed across both feet. Again, you should try to maintain stability for 20 seconds with your hands on your hips and your eyes closed. I will be counting the number of times you move out of this position. If you stumble out of this position, open your eyes and return to the start position and continue balancing. I will start timing when you are set and have closed your eyes."

Balance testing – types of errors

1. Hands lifted off iliac crest
2. Opening eyes
3. Step, stumble, or fall
4. Moving hip into > 30 degrees abduction
5. Lifting forefoot or heel
6. Remaining out of test position > 5 sec

Each of the 20-second trials is scored by counting the errors, or deviations from the proper stance, accumulated by the athlete. The examiner will begin counting errors only after the individual has assumed the proper start position. **The modified BESS is calculated by adding one error point for each error during the three 20-second tests. The maximum total number of errors for any single condition is 10.** If a athlete commits multiple errors simultaneously, only one error is recorded but the athlete should quickly return to the testing position, and counting should resume once subject is set. Subjects that are unable to maintain the testing procedure for a minimum of **five seconds** at the start are assigned the highest possible score, ten, for that testing condition.

OPTION: For further assessment, the same 3 stances can be performed on a surface of medium density foam (e.g., approximately 50 cm x 40 cm x 6 cm).

Tandem Gait^{6,7}

Participants are instructed to stand with their feet together behind a starting line (the test is best done with footwear removed). Then, they walk in a forward direction as quickly and as accurately as possible along a 38mm wide (sports tape), 3 meter line with an alternate foot heel-to-toe gait ensuring that they approximate their heel and toe on each step. Once they cross the end of the 3m line, they turn 180 degrees and return to the starting point using the same gait. A total of 4 trials are done and the best time is retained. Athletes should complete the test in 14 seconds. Athletes fail the test if they step off the line, have a separation between their heel and toe, or if they touch or grab the examiner or an object. In this case, the time is not recorded and the trial repeated, if appropriate.

Coordination Examination

Upper limb coordination

Finger-to-nose (FTN) task:

"I am going to test your coordination now. Please sit comfortably on the chair with your eyes open and your arm (either right or left) outstretched (shoulder flexed to 90 degrees and elbow and fingers extended), pointing in front of you. When I give a start signal, I would like you to perform five successive finger to nose repetitions using your index finger to touch the tip of the nose, and then return to the starting position, as quickly and as accurately as possible."

Scoring: 5 correct repetitions in < 4 seconds = 1

Note for testers: Athletes fail the test if they do not touch their nose, do not fully extend their elbow or do not perform five repetitions. **Failure should be scored as 0.**

References & Footnotes

1. This tool has been developed by a group of international experts at the 4th International Consensus meeting on Concussion in Sport held in Zurich, Switzerland in November 2012. The full details of the conference outcomes and the authors of the tool are published in The BJSM Injury Prevention and Health Protection, 2013, Volume 47, Issue 5. The outcome paper will also be simultaneously co-published in other leading biomedical journals with the copyright held by the Concussion in Sport Group, to allow unrestricted distribution, providing no alterations are made.
2. McCrory P et al., Consensus Statement on Concussion in Sport – the 3rd International Conference on Concussion in Sport held in Zurich, November 2008. British Journal of Sports Medicine 2009; 43: i76-89.
3. Maddocks, DL; Dicker, GD; Saling, MM. The assessment of orientation following concussion in athletes. Clinical Journal of Sport Medicine. 1995; 5(1): 32–3.
4. McCreary M. Standardized mental status testing of acute concussion. Clinical Journal of Sport Medicine. 2001; 11: 176–181.
5. Guskiewicz KM. Assessment of postural stability following sport-related concussion. Current Sports Medicine Reports. 2003; 2: 24–30.
6. Schneiders, A.G., Sullivan, S.J., Gray, A., Hammond-Tooke, G. & McCrory, P. Normative values for 16-37 year old subjects for three clinical measures of motor performance used in the assessment of sports concussions. Journal of Science and Medicine in Sport. 2010; 13(2): 196–201.
7. Schneiders, A.G., Sullivan, S.J., Kvamstrom, J.K., Olsson, M., Yden, T. & Marshall, S.W. The effect of footwear and sports-surface on dynamic neurological screening in sport-related concussion. Journal of Science and Medicine in Sport. 2010; 13(4): 382–386

Any athlete suspected of having a concussion should be removed from play, and then seek medical evaluation.

Problems could arise over the first 24–48 hours. The athlete should not be left alone and must go to a hospital at once if they:

- Have a headache that gets worse
- Are very drowsy or can't be awakened
- Can't recognize people or places
- Have repeated vomiting
- Behave unusually or seem confused; are very irritable
- Have seizures (arms and legs jerk uncontrollably)
- Have weak or numb arms or legs
- Are unsteady on their feet; have slurred speech

Consult your doctor after a suspected concussion.

Athletes should not be returned to play the same day of injury.

When returning athletes to play, they should be **medically cleared and then follow a stepwise supervised program**, with stages of progression.

Rehabilitation stage	Functional exercise at each stage of rehabilitation	Objective of each stage
No activity	Physical and cognitive rest	Recovery
Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity 70% maximum predicted heart rate. No resistance training	Increase heart rate
Sport-specific exercise	Skating drills in ice hockey, running drills in soccer. No head impact activities	Add movement
Non-contact training drills	Progression to more complex training drills, eg passing drills in football and ice hockey. May start progressive resistance training	Exercise, coordination, and cognitive load
Full contact practice	Following medical clearance participate in normal training activities	Restore confidence and assess functional skills by coaching staff
Return to play	Normal game play	

If the athlete is symptomatic for more than 10 days, then consultation by a medical practitioner who is expert in the management of concussion, is recommended.

Medical clearance should be given before return to play.

(To be given to the **person monitoring** the concussed athlete)

If you notice any change in behaviour, vomiting, dizziness, worsening headache, double vision or excessive drowsiness, please contact your doctor or the nearest hospital emergency department immediately.

- Rest (physically and mentally), including training or playing sports until symptoms resolve and you are medically cleared
- No alcohol
- No prescription or non-prescription drugs without medical supervision.
Specifically:
 - No sleeping tablets
 - Do not use aspirin, anti-inflammatory medication or sedating pain killers
- Do not drive until medically cleared
- Do not train or play sport until medically cleared

Test Domain	Score		
	Date: ____	Date: ____	Date: ____
Number of Symptoms of 22			
Symptom Severity Score of 132			
Orientation of 5			
Immediate Memory of 15			
Concentration of 5			
Delayed Recall of 5			
SAC Total			
BESS (total errors)			
Tandem Gait (seconds)			
Coordination of 1			

This image shows a single sheet of white paper with horizontal blue lines, resembling notebook paper. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Treating physician

Contact details or stamp

Appendix C- Vestibular/Ocular Motor Screen Form

Vestibular/Ocular-Motor Screening (VOMS) for Concussion

Vestibular/Ocular Motor Test:	Not Tested	Headache 0-10	Dizziness 0-10	Nausea 0-10	Fogginess 0-10	Comments
BASELINE SYMPTOMS:	N/A					
Smooth Pursuits						
Saccades – Horizontal						
Saccades – Vertical						
Convergence (Near Point)						(Near Point in cm): Measure 1: _____ Measure 2: _____ Measure 3: _____
VOR – Horizontal						
VOR – Vertical						
Visual Motion Sensitivity Test						

Instructions:

Interpretation: This test is designed for use with subjects ages 9-40. When used with patients outside this age range, interpretation may vary. Abnormal findings or provocation of symptoms with any test may indicate dysfunction – and should trigger a referral to the appropriate health care professional for more detailed assessment and management.

Equipment: Tape measure (cm); Metronome; Target w/ 14 point font print.

Baseline Symptoms – Record: Headache, Dizziness, Nausea & Fogginess on 0-10 scale prior to beginning screening

- **Smooth Pursuits** - Test the ability to follow a slowly moving target. The patient and the examiner are seated. The examiner holds a fingertip at a distance of 3 ft. from the patient. The patient is instructed to maintain focus on the target as the examiner moves the target smoothly in the horizontal direction 1.5 ft. to the right and 1.5 ft. to the left of midline. One repetition is complete when the target moves back and forth to the starting position, and 2 repetitions are performed. The target should be moved at a rate requiring approximately 2 seconds to go fully from left to right and 2 seconds to go fully from right to left. The test is repeated with the examiner moving the target smoothly and slowly in the vertical direction 1.5 ft. above and 1.5 ft. below midline for 2 complete repetitions up and down. Again, the target should be moved at a rate requiring approximately 2 seconds to move the eyes fully upward and 2 seconds to move fully downward. Record: Headache, Dizziness, Nausea & Fogginess ratings after the test. (Figure 1)
- **Saccades** – Test the ability of the eyes to move quickly between targets. The patient and the examiner are seated.
 - **Horizontal Saccades:** The examiner holds two single points (fingertips) horizontally at a distance of 3 ft. from the patient, and 1.5 ft. to the right and 1.5 ft. to the left of midline so that the patient must gaze 30 degrees to left and 30 degrees to the right. Instruct the patient to move their eyes as quickly as possible from point to point. One repetition is complete when the eyes move back and forth to the starting position, and 10 repetitions are performed. Record: Headache, Dizziness, Nausea & Fogginess ratings after the test. (Figure 2)

- Vertical Saccades:** Repeat the test with 2 points held vertically at a distance of 3 ft. from the patient, and 1.5 feet above and 1.5 feet below midline so that the patient must gaze 30 degrees upward and 30 degrees downward. Instruct the patient to move their eyes as quickly as possible from point to point. One repetition is complete when the eyes move up and down to the starting position, and 10 repetitions are performed. Record: Headache, Dizziness, Nausea & Foggiess ratings after the test. (Figure 3)
- Convergence** – Measure the ability to view a near target without double vision. The patient is seated and wearing corrective lenses (if needed). The examiner is seated front of the patient and observes their eye movement during this test. The patient focuses on a small target (approximately 14 point font size) at arm's length and slowly brings it toward the tip of their nose. The patient is instructed to stop moving the target when they see two distinct images or when the examiner observes an outward deviation of one eye. Blurring of the image is ignored. The distance in cm. between target and the tip of nose is measured and recorded. This is repeated a total of 3 times with measures recorded each time. Record: Headache, Dizziness, Nausea & Foggiess ratings after the test. Abnormal: Near Point of convergence ≥ 6 cm from the tip of the nose. (Figure 4)
- Vestibular-Ocular Reflex (VOR) Test** – Assess the ability to stabilize vision as the head moves. The patient and the examiner are seated. The examiner holds a target of approximately 14 point font size in front of the patient in midline at a distance of 3 ft.
 - Horizontal VOR Test:** The patient is asked to rotate their head horizontally while maintaining focus on the target. The head is moved at an amplitude of 20 degrees to each side and a metronome is used to ensure the speed of rotation is maintained at 180 beats/minute (one beat in each direction). One repetition is complete when the head moves back and forth to the starting position, and 10 repetitions are performed. Record: Headache, Dizziness, Nausea and Foggiess ratings 10 sec after the test is completed. (Figure 5)
 - Vertical VOR Test:** The test is repeated with the patient moving their head vertically. The head is moved in an amplitude of 20 degrees up and 20 degrees down and a metronome is used to ensure the speed of movement is maintained at 180 beats/minute (one beat in each direction). One repetition is complete when the head moves up and down to the starting position, and 10 repetitions are performed. Record: Headache, Dizziness, Nausea and Foggiess ratings after the test. (Figure 6)
- Visual Motion Sensitivity (VMS) Test** – Test visual motion sensitivity and the ability to inhibit vestibular-induced eye movements using vision. The patient stands with feet shoulder width apart, facing a busy area of the clinic. The examiner stands next to and slightly behind the patient, so that the patient is guarded but the movement can be performed freely. The patient holds arm outstretched and focuses on their thumb. Maintaining focus on their thumb, the patient rotates, together as a unit, their head, eyes and trunk at an amplitude of 80 degrees to the right and 80 degrees to the left. A metronome is used to ensure the speed of rotation is maintained at 50 beats/min (one beat in each direction). One repetition is complete when the trunk rotates back and forth to the starting position, and 5 repetitions are performed. Record: Headache, Dizziness, Nausea & Foggiess ratings after the test. (Figure 7)

Appendix D- Head Injury Home Care Instructions



Head Injury Home Care Instructions

Dear _____,

Your son/daughter injured their head during _____. A careful medical evaluation has been completed and no signs of serious complications were found at this time. However, your child did demonstrate signs and symptoms suggestive of a concussion. IMSA policy requires that your child remain off campus until seen by a physician and appropriate orders are received from that doctor. It is expected that recovery should be rapid, but your child should be monitored for a period by a responsible adult. More serious brain injuries have symptoms that may not reveal themselves until hours or even a day after the initial incident. You should take your son/daughter to the nearest emergency department immediately if any of the following occur:

- Loss of consciousness
- Seizures
- Worsening headache
- Vomiting
- Abnormal personality changes
- Loss of coordination
- Weakness in any extremity
- Vision disturbances
- Unequal pupil size
- Unusual confusion or forgetfulness
- Abnormally drowsy or difficult to awaken

Otherwise, in order to ensure the most rapid recovery for your child, they need to get plenty of rest (both physical and mental), stay hydrated, and eat a healthy, balanced diet. They should not take any pain or anti-inflammatory medications without consulting a physician. These medications may mask some of the above listed symptoms. Additionally, there is no need to wake your child every few hours during the night unless directed to do so by a physician. This practice can disrupt the much needed sleep required for recovery. Your child should be seen by a physician experienced in concussion management within 3 days of the incident so a specific treatment plan can be put in place for your child.

Please have your son/daughter contact the athletic trainer within a day of the incident. They will require a follow-up medical evaluation in order to track their recovery as well as to allow for the safest return to school and competition. Your child will be evaluated and allowed to return to activity in a progressive manner as laid out in the currently effective edition of the *IMSA Concussion Management Protocol*. This protocol is available for review in the concussion section of the IMSA Sports Medicine website (imsasportsmedicine.weebly.com/concussions.html), which also can be found by following the link on the IMSA Athletics webpage (www.imsa.edu/studentlife/athletics).

Please feel free to contact me at any time should you have any questions or concerns.

Certified Athletic Trainer

Date

Cell Phone Number

Appendix E- School Recommendations Following Concussion Form



ILLINOIS MATHEMATICS AND SCIENCE ACADEMY

Phone: (630)907-5008

Fax: (630)907-5938

School Recommendations Following Concussion

Patient Name: _____

Date of Birth: _____

Date of Evaluation: _____

Referred by: _____

Diagnosis: _____

The patient will be reassessed for revision of these recommendations in _____ weeks.

May return to school on _____ (date) or when _____

Current Symptom List (the student is noting these today)

___ Headache	___ Visual problems	___ Sensitivity to noise	___ Memory issues
___ Nausea	___ Balance problems	___ Feeling foggy	___ Fatigue
___ Dizziness	___ Sensitivity to light	___ Difficulty concentrating	___ Irritability
___ Other: _____			

Please circle the Return to Learn step you prescribe for your patient to begin and note suggested accommodations.

Step	Intensity	Cognitive Activity	Suggested Accommodations
1	No Activity, No School	<ul style="list-style-type: none"> Rest 	
2	Begin accommodated school days	<ul style="list-style-type: none"> Allow accommodations for symptoms ½ day of school or allow to rest in Health Office No tests or quizzes until student has attended at least one class post-concussion Suggestion to work on homework in 30 minute intervals PE –no physical exertion No participation in after school activities Meet with College and Academic Counselor, Learning Strategies Coordinator or Assistant Principal to create academic plan 	
3	Full day of school with accommodations	<ul style="list-style-type: none"> Allow accommodations for symptoms Attend all classes; rest in Health Office if symptomatic Meet with College and Academic Counselor, Learning Strategies Coordinator or Assistant Principal to create academic plan and receive permission to participate in after school activities PE activity level per recommendations Test or quizzes may be limited to one per day Athletes take Post Injury – NP Test 	
4	Return to full cognitive activity	<ul style="list-style-type: none"> Full day of school Full classwork and resume physical activity in PE Meet with College and Academic Counselor, Learning Strategies Coordinator or Assistant Principal to create plan to complete outstanding work and meet adjusted deadlines Athletes complete Return to Play protocol 	

Possible accommodations include: No physical exertion in PE or no PE, No Band or Chorus, Partial days of classes as tolerated, Use of sunglasses/hat in school, Limited use of technology, Reduced homework load/extensions; Additional time and/or alternate location for tests, No more than one test per day, Use of in class textbook

Please check **ONE** below:

- ☐ IMSA must contact you to progress with Return to Learn and Return to Play protocols.
- ☐ IMSA can progress with Return to Learn and Return to Play as symptoms dictate, but student must be evaluated by your office before full release (2nd visit needed)
- ☐ Once the Return to Learn and Return to Play protocols are completed your patient can be released to full cognitive and physical activity.

Physician Signature _____ Date _____

Print Name _____

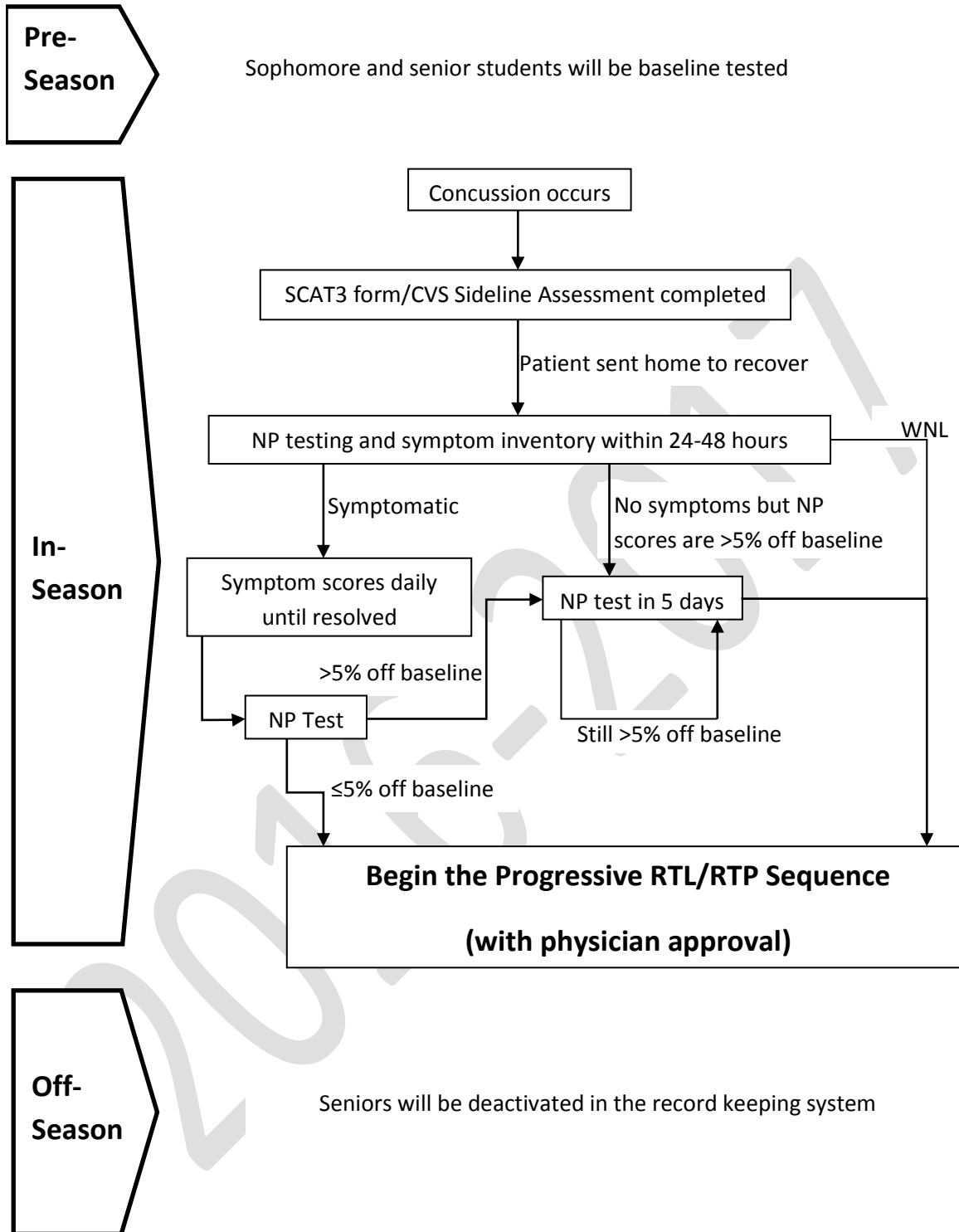
Office Phone & Fax _____

I, _____ (parent/guardian) give permission for Dr. _____ to share the following information with IMSA and for communication to occur between the school and Dr. _____ for changes to this plan

Parent/Guardian Signature _____

Date _____

Appendix F- Computerized Neuropsychological Testing Utilization Algorithm



Appendix G- IHSA Post Concussion Consent Form



Post-concussion Consent Form
(RTP/RTL)



Date _____

Student's Name _____ Year in School 9 10 11 12

By signing below, I acknowledge the following:

1. I have been informed concerning and consent to my student's participating in returning to play in accordance with the return-to-play and return-to-learn protocols established by Illinois State law;
2. I understand the risks associated with my student returning to play and returning to learn and will comply with any ongoing requirements in the return-to-play and return-to-learn protocols established by Illinois State law;
3. And I consent to the disclosure to appropriate persons, consistent with the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), of the treating physician's or athletic trainer's written statement, and, if any, the return-to-play and return-to-learn recommendations of the treating physician or the athletic trainer, as the case may be.

Student's Signature _____

Parent/Guardian's Name _____

Parent/Guardian/s Signature _____

For School Use only

☐

Written statement is included with this consent from treating physician or athletic trainer working under the supervision of a physician that indicates, in the individual's professional judgement, it is safe for the student to return-to-play and return-to-learn.

Cleared for RTL

Date _____

Cleared for RTP

Date _____

Appendix H- Pre-Season Concussion Education and Acknowledgement of Risk Form



Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a “ding” or a bump on the head can be serious. You can’t see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:	
<ul style="list-style-type: none">• Headaches• “Pressure in head”• Nausea or vomiting• Neck pain• Balance problems or dizziness• Blurred, double, or fuzzy vision• Sensitivity to light or noise• Feeling sluggish or slowed down• Feeling foggy or groggy• Drowsiness• Change in sleep patterns	<ul style="list-style-type: none">• Amnesia• “Don’t feel right”• Fatigue or low energy• Sadness• Nervousness or anxiety• Irritability• More emotional• Confusion• Concentration or memory problems (forgetting game plays)• Repeating the same question/comment

Signs observed by teammates, parents and coaches include:
<ul style="list-style-type: none">• Appears dazed• Vacant facial expression• Confused about assignment• Forgets plays• Is unsure of game, score, or opponent• Moves clumsily or displays incoordination• Answers questions slowly• Slurred speech• Shows behavior or personality changes• Can’t recall events prior to hit• Can’t recall events after hit• Seizures or convulsions• Any change in typical behavior or personality• Loses consciousness



IHSA Sports Medicine Acknowledgement & Consent Form

Concussion Information Sheet (Cont.)

What can happen if my child keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often fail to report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents and students is the key to student-athlete's safety.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. IHSA Policy requires athletes to provide their school with written clearance from either a physician licensed to practice medicine in all its branches or a certified athletic trainer working in conjunction with a physician licensed to practice medicine in all its branches prior to returning to play or practice following a concussion or after being removed from an interscholastic contest due to a possible head injury or concussion and not cleared to return to that same contest. In accordance with state law, all IHSA member schools are required to follow this policy.

You should also inform your child's coach if you think that your child may have a concussion. Remember it's better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:
<http://www.cdc.gov/ConcussionInYouthSports/>



IHSA Performance-Enhancing Substance Testing Policy

In 2008, the IHSA Board of Directors established the association's Performance-Enhancing Substance (PES) Testing Program. Any student who participates in an IHSA-approved or sanctioned athletic event is subject to PES testing. A full copy of the testing program and other related resources can be accessed on the IHSA Sports Medicine website. Additionally, links to the PES Policy and the association's Banned Drug classes are listed below. School administrators are able to access the necessary resources used for program implementation in the IHSA Schools Center.

IHSA PES Testing Program

<http://www.ihsa.org/documents/sportsMedicine/2015-16/2015-16%20PES%20policy%20final.pdf>

IHSA Banned Drug Classes

<http://www.ihsa.org/documents/sportsMedicine/2015-16/2015-16%20IHSA%20Banned%20Drugs.pdf>

insert Consent Language here (w/o signature lines)

IHSA Steroid Testing Policy Consent to Random Testing

As a prerequisite to participation in IHSA athletic activities, we agree that I/our student will not use performance-enhancing substances as defined in the IHSA Performance-Enhancing Substance Testing Program Protocol. We have reviewed the policy and understand that I/our student may be asked to submit to testing for the presence of performance-enhancing substances in my/our student's body either during IHSA state series events or during the school day, and I/our student do/does hereby agree to submit to such testing and analysis by a certified laboratory. We further understand and agree that the results of the performance-enhancing substance testing may be provided to certain individuals in my/our student's high school as specified in the IHSA Performance-Enhancing Substance Testing Program Protocol which is available on the IHSA website at www.IHSA.org. We understand and agree that the results of the performance-enhancing substance testing will be held confidential to the extent required by law. We understand that failure to provide accurate and truthful information could subject me/our student to penalties as determined by IHSA.

A complete list of the current IHSA Banned Substance Classes can be accessed at <http://www.ihsa.org/documents/sportsMedicine/2015-16/2015-16%20IHSA%20Banned%20Drugs.pdf>



IHSA Sports Medicine Acknowledgement & Consent Form

Acknowledgement and Consent

Student/Parent Consent and Acknowledgements

By signing this form, we acknowledge we have been provided information regarding concussions and the IHSA Performance-Enhancing Testing Policy. We also acknowledge that we are providing consent to be tested in accordance with the procedures outlined in the IHSA Performance-Enhancing Testing Policy.

STUDENT

Student Name (Print): _____ Grade (9-12) _____

Student Signature: _____ Date: _____

PARENT or LEGAL GUARDIAN

Name (Print): _____

Signature: _____ Date: _____

Relationship to student: _____

Consent to Self Administer Asthma Medication

Illinois Public Act 098-0795 provides new directions for schools concerning the self-carry and self-administration of asthma medication by students. In order for students to carry and self-administer asthma medication, parents or guardians must provide schools with the following:

- Written authorization from a student's parents or guardians to allow the student to self-carry and self-administer the medication.
- The prescription label, which must contain the name of the asthma medication, the prescribed dosage, and the time at which or circumstances under which the asthma medication is to be administered.

A full copy of the law can be found at <http://www.ilga.gov/legislation/publicacts/98/PDF/098-0795.pdf>.