

Dear Parent/Guardian,

Your student-athlete has sustained a possible concussion. This packet contains the paperwork necessary for your student-athlete to return to academics as well as return to sports participation. A head injury information sheet is attached; please reference the signs and symptoms described to monitor your student-athletes condition.

Your student-athlete will be removed from activity/athletic participation until symptom free and cleared by a physician. Please see the step by step process below. If you have any questions or concerns, please contact the appropriate athletic trainer or your school's athletic director.

Step 1: Initial Evaluation by a Physician

- The physician of your choice must be a MD/DO, not a chiropractor, nurse practitioner, or physician assistant.
- Lee Memorial Health System offers a concussion clinic through the FSU Family Residency Program (239) 343-3831.
- If a concussion or other head injury is not diagnosed, please get that in writing and return to coach/athletic director/athletic trainer and disregard the steps below.
- If diagnosed with a concussion or other head injury, please follow the next steps 2-4.
 - If symptom free during initial physician evaluation, please skip to step 4.

Step 2: Return to Learn Form

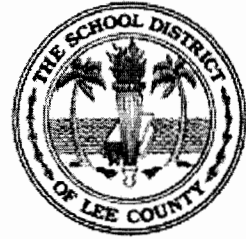
- If the student-athlete needs accommodations in the classroom throughout the healing process, please have the treating physician complete and return it to the clinic assistant/school nurse.

Step 3: Return to School

- When the student-athlete returns to school, they need to report to the clinic. The clinic assistant/school nurse will notify the teachers of the injury and possible signs and symptoms to look for as well as remove them from PE/ROTC classes where physical activity is required.
- The athlete can report to the clinic throughout the day if needed due to the increase of symptoms.

Step 4: Return to Play

- When the athlete has returned to normal classroom activity and symptom free, return to the treating physician for clearance to begin the Return to Play FHSAA AT18 form.



Head Injury Information

What is a concussion?

A concussion is a brain injury caused by a blow to the head or body that causes the brain to move rapidly inside the skull. Concussions can also result from a fall or from collisions between with one or more individuals or obstacles. They disrupt normal brain function, and can range from mild to severe. A concussion is possible from a minor bump and can occur even without loss of consciousness. As brain injury, concussions are serious.

What are the signs and symptoms?

Signs (observed by others)

- a. Athlete appears dazed or stunned
- b. Confusion (about assignment, plays, etc.)
- c. Forgets plays
- d. Unsure about game, score, opponent
- e. Moves clumsily (altered coordination)
- f. Balance problems
- g. Personality change
- h. Responds slowly to questions
- i. Forgets events prior to hit
- j. Forgets events after the hit
- k. Loss of consciousness (any duration)

Symptoms (reported by athlete):

- a. Headache
- b. Fatigue
- c. Nausea or vomiting
- d. Double vision, blurry vision
- e. Sensitive to light or noise
- f. Feels sluggish
- g. Feels "foggy"
- h. Problems concentrating
- i. Problems remembering

The signs, symptoms, and behaviors of a concussion are not always apparent immediately after a bump, blow, or jolt to the head or body and may develop over a few hours. An athlete should be observed following a suspected concussion and should never be left alone.

What to do?

If your child experiences any of the following, call your Doctor or go to the Emergency room immediately!

- Increased drowsiness, mental confusion or difficult to arouse
- Vomiting, nausea, fever or neck stiffness
- Weakness of face, arms or legs, difficulty balancing
- Blurred or double vision
- Slurred Speech
- Increased severity of a headache
- Seizures
- Drainage of blood or clear fluid from nose or ears
- Any other new or worsening symptoms that concerns you

If your child has any visible bumps or swelling you should apply an ice bag intermittently for the next 24 hours.

Returning to School Procedures:

1. If your child is still having symptoms of concussion they may need extra help to perform school-related activities. If so, please have the treating physician complete a Return to Learn form.
2. As your child's symptoms decrease during recovery, the extra help or supports can be removed gradually.

(Returning to School Procedures cont'd.)

3. Notify the school nurse or clinic aid and athletic director upon return to school. If completed, turn in the Return to Learn form to the school nurse at this time.
4. School personnel will be instructed to watch for:
 - Increased problems paying attention or concentrating
 - Increased problems remembering or learning new information
 - Longer time needed to complete tasks or assignments
 - Greater irritability, less able to cope with stress
 - Symptoms worsen (e.g., headache, tiredness) when doing schoolwork
5. Communicate with your teachers, school nurse, clinic aid, athletic director and/or guidance counselor regarding your status throughout the school day.
6. Follow up with your Athletic Trainer for an ImPact post-test if available.

Returning to Play Procedures:

The FHSAA Return to Play (RTP) Criteria: Concussion Management

1. No athlete should return to play (RTP) or practice on the same day of a concussion. "When in doubt, sit them out!"
2. Any athlete suspected of having a concussion must be evaluated by an AHCP (Appropriate Health-Care Professional: MD or DO) as soon as possible and practical.
3. Any athlete who has sustained a concussion must be medically cleared by an AHCP prior to resuming participation in any practice or competition.
4. After the athlete is symptom free and ImPact test as returned to normal (if available), the athlete may seek evaluation and examination by an AHCP to receive clearance to begin RTP on the **Form AT18 (Post Head Injury/Concussion) Page 1**.
5. Return to play must follow a step-wise protocol as defined by the "Graded Return to Play Protocol" form and under the supervision of an AHCP, Athletic Trainer, coach, or other health care professional. **Form AT18 (Post Head Injury/Concussion) Page 1**.
6. A written medical clearance from an AHCP is required for return to competition. **Form AT18 Page 2**.

Symptom Referral Sheet

Name _____ M / F Birthdate _____ Date of Injury _____

Sport/Team/School _____ Prior concussions: How Many? _____ Most Recent : _____ Length of recovery _____

Symptom Evaluation					
none mild moderate severe 0 1 2 3 4 5 6					
	Score		Score		Score
1. Headache		9. Sensitivity to noise		17. Drowsiness	
2. Pressure in head		10. Feeling slowed down		18. Trouble falling asleep	
3. Neck Pain		11. Feeling like in a fog		19. More emotional	
4. Nausea or Vomiting		12. Don't feel right		20. Irritability	
5. Dizziness		13. Difficulty concentrating		21. Sadness	
6. Blurred vision		14. Difficulty remembering		22. Nervous or anxious	
7. Balance problems		15. Fatigue or low energy		Total # of Symptoms:	
8. Sensitivity to light		16. Confusion		Symptom Severity :	

Physical Signs Score	
Was there loss of consciousness or unresponsiveness? Y/N	If yes how long? _____ Minutes
Was there a balance problem/unsteadiness? Y/N	
Total: ___/2	

Ocular Motor Testing	
Ocular Motor Test	Findings
1. Spontaneous Nystagmus	<input type="checkbox"/> absent <input type="checkbox"/> right beating <input type="checkbox"/> left beating <input type="checkbox"/> upward beating <input type="checkbox"/> downward beating
2. Smooth Pursuits-horizontal	<input type="checkbox"/> intact <input type="checkbox"/> saccadic <input type="checkbox"/> symptomatic
3. Smooth Pursuits-vertical	<input type="checkbox"/> intact <input type="checkbox"/> saccadic <input type="checkbox"/> symptomatic
4. Saccades-horizontal	<input type="checkbox"/> intact <input type="checkbox"/> undershoots <input type="checkbox"/> overshoots <input type="checkbox"/> symptomatic
5. Saccades-vertical	<input type="checkbox"/> intact <input type="checkbox"/> undershoots <input type="checkbox"/> overshoots <input type="checkbox"/> symptomatic
6. Near Point of convergence	<input type="checkbox"/> _____ cm <input type="checkbox"/> symptomatic

Memory and Balance Tests	
Tests	Findings
1. Retrograde Memory	<input type="checkbox"/> Intact <input type="checkbox"/> Symptomatic
2. Immediate Memory	<input type="checkbox"/> Intact <input type="checkbox"/> Symptomatic
3. Concentration	<input type="checkbox"/> Intact <input type="checkbox"/> Symptomatic
4. Balance	<input type="checkbox"/> Intact <input type="checkbox"/> Symptomatic
5. Delayed Recall	<input type="checkbox"/> Intact <input type="checkbox"/> Symptomatic

Notes/Mechanism of Injury
Referring Athletic Trainer: _____ Date: _____

Lee Concussion Partnership – Return To Learn



Name _____ DOB _____ Injury Date _____

Sport/Team/School _____ Phone _____

Primary Care Physician _____ Phone _____

Concussion Management Team Leader _____ Phone _____

STUDENT MAY NOT ATTEND SCHOOL AT THIS TIME. Student may not attend class and should not work on homework assignments, reading projects, etc. This includes no extracurricular activities, such as all athletic activity, weightlifting, gym class, band, music, debate, etc. Continue to limit at home activities that can worsen symptoms, such as loud music, television, computer screen time, texting, etc.

BREAKS & ACCOMMODATIONS.* Student may attend school with accommodations. Access to the clinic, as needed, for breaks during the school day if symptoms worsen. Special accommodations may be required to limit symptoms to include homework, classwork, and classroom tests until student is cleared. Participation in all athletic or physical activity and extracurricular activities is still fully restricted.

FULL SCHEDULE & ACCOMMODATIONS.* Student may participate in a normal classroom schedule, but may require some accommodations, depending on their current symptoms. All athletic or physical activity is still not allowed, but the student can start to participate in non-athletic extracurricular activities as tolerated.

Gradually increase school participation and independence as tolerated by the student. The student is responsible to complete all assignments missed throughout the healing process. Goal is to achieve full return to school without accommodations.

NORMAL CLASSROOM. Student is cleared for Normal Classroom Activities and "Post Head Injury/Concussion Initial Return to Participation" (AT18 Form – Page 1 must be signed by Physician)

Medical Professional Signature: _____ Date _____

Scheduled Follow-up Date _____

Notes: _____

*Concussion symptoms may develop within days after a head injury. The patient should continue to be observed for any new symptoms. *School management team will meet to determine appropriate accommodations on an individual basis.*



Post Head Injury/Concussion Initial Return to Participation

(Page 1 of 2)

This form is to be completed by an appropriate health care provider (AHCP-MD/DO) trained in the latest concussion evaluation and management protocols as defined in FHSAA policy 40.2 for any student-athlete that has sustained a concussion and must be kept on file at the student-athlete's school. The choice of AHCP remains the decision of the parent/guardian or responsible party of the student-athlete.

Athlete Name: _____ DOB: ____/____/____ Injury Date: ____/____/____

Sport: _____ School: _____ Level (Varsity, JV, etc.): _____

I (treating physician) certify that the above listed athlete has been evaluated for a concussive head injury, and currently is/has:
(All Boxes MUST be checked before proceeding)

Asymptomatic Normal neurological exam

Off medications related to this concussion Returned to normal classroom activity

.....

Yes *or* N/A Neuropsychological testing (as available) has returned to baseline

The athlete named above is cleared to begin a graded return to play protocol (outline below) under the supervision of an athletic trainer, coach or other health care professional as of the date indicated below. If the athlete experiences a return of any of his/her concussion symptoms while attempting a graded return to play, the athlete is instructed to stop play immediately and notify a parent, licensed athletic trainer or coach.

By signing below, I certify that I am a medical doctor (MD/DO) familiar with the most current 2016 Consensus Statement on Concussion in Sport and the tools used for evaluation (ex. SCAT5). This information will be used to guide return to play progression (page 1) and final clearance to return to competition.

Physician Name: _____ Signature/Degree: _____ MD/DO

Phone: _____ Fax: _____ Today's Date: _____

Graded Return to Play Protocol

After a brief period of initial rest (24-48 hr), symptom-limited activity can begin while staying below a cognitive and physical exacerbation threshold.

Once concussion-related symptoms have resolved, the athlete should continue to proceed to the next level if he/she meets all criteria without recurrence of symptoms. Generally each step should take at least 24 hrs, however, this time frame may vary with player age, history, level of sport, etc., and management must be individualized.

Rehabilitation stage	Functional exercise at each stage	Objective	Date completed	Initials
1. Symptom limited activity	Daily activities that do not provoke symptoms	Gradual reintroduction of work/school activities	Noted above	Signed above
2. Light aerobic exercise	Walking, swimming, stationary bike, HR<70% maximum: no weight training	Increased heart rate		
3. Sport-specific exercise	Non-contact drills, running drills: no impact	Add movement		
4. Non-contact training	Complex (non-contact) drills/practice	Exercise, coordination and cognitive load		
5. Full contact practice	Full contact practice, normal activities	Restore confidence and simulate game situations		
6. Return to full activity	Return to competition	After completion of the steps above; Form AT18, Page 2 must be completed by physician		

I attest the above named athlete has completed the graded return to play protocol as dated above.

Athletic Trainer / Coach Name: _____ AT License Number: _____ Phone: _____

Athletic Trainer / Coach Signature: _____ Date: ____/____/____

Physician Reviewed:



Florida High School Athletic Association

Post Head Injury/Concussion Initial Return to Participation

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This form is to be completed by an appropriate health care provider (MD/DO) trained in the latest concussion evaluation and management protocols as defined in FHSAA policy 40.2 for any student-athlete that has sustained a concussion and must be kept on file at the student-athlete's school. The choice of AHCP-MD/DO remains the decision of the parent/guardian or responsible party of the student-athlete. Completion of this form in itself does not guarantee playing time for the athlete.

Return to Competition Affidavit

Student-Athlete's Name: _____

Date of Birth: ____/____/____ Injury Date: ____/____/____

Formal Diagnosis: _____

School: _____

Sport: _____

I certify that I have reviewed the signed graded return to activity protocol provided to me on behalf of the athlete named above. This athlete is cleared for a complete return to **full-contact physical activity** as of ____/____/____.

This student-athlete is instructed to stop play immediately and notify a parent, licensed athletic trainer or coach and to refrain from activity should his/her symptoms return.

Physician Name: _____

Physician Signature: _____ MD/DO License No.: _____

Phone: (____) _____ Fax: (____) _____ E-mail: _____

Date: ____/____/____

By signing above, I certify that I am a medical doctor (MD/DO) familiar with the most current 2016 Consensus Statement on Concussion in Sport and the tools used for evaluation (ex: SCAT5). This information will be used to guide return to play progression (page 1) and final clearance to return to competition.