WATERVLIET CITY SCHOOL DISTRICT
CONCUSSION MANAGEMENT PLAN AND PROCEDURES

HEAD/BRAIN INJURY INFORMATION
FOR PARENTS and STUDENT/ATHLETES

Dear Parent:

Your son/daughter has suffered a head/brain injury. Head/brain injuries vary greatly in severity. Though most severe head/brain injuries can be recognized at the time of the incident, the signs and symptoms of others may be delayed. It is, therefore, extremely important that any athlete who has sustained a symptom bearing concussive blow to the head or body be observed closely for **at least twenty-four hours.** Call your family physician or take your child to the emergency room if any of the following occur:

-- Headache continues to worsen
-- Impaired memory
-- Unusual drowsiness or difficult to arouse
-- Changes in level of consciousness, alertness, or personality
-- Blood or other fluids draining from ears or nose
-- Convulsions or seizures
-- Dizziness, loss of coordination or balance
-- Disturbances in vision, hearing or speech
-- Nausea or vomiting
-- He/she appears confused or unable to concentrate
-- Pupils become dilated or unequal in size/shape
-- Weakness or numbness of arms, legs, or trouble walking
-- Fever and stiff neck
-- Sleep disturbance
-- Anxious or irritable

Please remind your child to report to the School Nurse the next day he/she attends school at a convenient time! It is the parent's responsibility to have the enclosed forms signed and returned to the school's medical staff!

Return to Play / Activity Protocol Following a Concussion

The following protocol has been established in accordance with the National Federation of State High School Associations and the International Conference on Concussion in Sport, Zurich 2008 Guidelines. In addition, it has been fabricated in a collaborative effort with concussion experts in the upstate New York area, the Watervliet City School District, supervising medical officer, and the concussion management team (school physician, high school principal, athletic director, school nurse). As such, it is imperative to remember the safety of the student is the primary concern of Watervliet City School District and its medical personnel. The information contained below is to be used as mere guidelines that are to be implemented in the time following a concussion event.

When a Student shows signs or symptoms of a concussion or is suspected to have sustained a brain injury after an evaluation by coaching staff or medical personal at the time of the incident:

1. The Student **will not** be allowed to return to play/activity in the current game or practice.
2. The Student should not be left alone, and regular monitoring for deterioration is essential over the next 24 hours following injury.
3. Following the initial injury, the Student **must follow up** with their Primary Care Physician or with an Urgent Care/ Emergency Care Facility within the first 24 hours.
4. The student **must have** the "Student/Athlete Initial Concussion Checklist" completed by the School Nurse and the "Concussion Checklist Physician Evaluation" signed and dated by a physician, nurse practitioner, or physician's assistant. These forms **must be** returned to the School Nurse at Watervliet City School District.
5. Return to play **must follow** a medical clearance and successful completion of the "Return to Play Protocol."
6. The School Nurse will supervise and document the Zurich Guidelines. The school district appointed M.D. has final determination for student's return to play status.

The cornerstone of proper concussion management is rest until all symptoms resolve and then a graded program of exertion before return to sport/activity. The program is broken down into six steps in which **only one step is covered per one 24-hour period.** *The six steps involved with the* ***Return to Play Protocol*** are:

1. No exertional activity until asymptomatic.
2. Light aerobic exercise such as brisk walking or stationary bike, etc. No resistance training.
3. Sport/activity specific exercise such as skating, running, etc. Progressive addition of light resistance training.
4. Non-contact training/skill drills.
5. Full contact training in practice setting (if a contact/collision sport).
6. Return to competition.

If any concussion symptoms recur, the athlete should drop back to the previous level and try to progress after 24 hours of rest. In addition, the student-athlete should also be monitored for recurrence of symptoms due to mental exertion, such as reading, working on a computer, or taking a test.

If you have any questions regarding this concussion plan, please don't hesitate to call the Athletic Office at 629-3303.

WATERVLIET STUDENT / ATHLETE INITIAL CONCUSSION CHECKLIST

To be filled out by Coach and School Nurse
Original copy must be returned to the School Nurse

Student Name _____ Age ____ Sport _____ Injury Date _____

Student Parents' Name _____ Location of Sporting Event _____

Student Parents' Phone Number: Home (___)-_____ Work (___)-_____ Cell (___)-_____

CIRCLE YES or NO FOR SYMPTOMS OBSERVED OR REPORTED AT TIME OF INJURY:

Dizziness	**Yes**	**No**	**Unconsciousness**	**Yes**	**No**
Ringing in Ears	**Yes**	**No**	**Fatigue/Low Energy**	**Yes**	**No**
Drowsy/Sleepy	**Yes**	**No**	**Feeling Dazed**	**Yes**	**No**
"Doesn't Feel Right"	**Yes**	**No**	**Poor Balance/Coordination**	**Yes**	**No**
Seizure	**Yes**	**No**	**Loss of Orientation**	**Yes**	**No**
Memory Problems	**Yes**	**No**	**Sensitivity to Light**	**Yes**	**No**
Blurred Vision	**Yes**	**No**	**Sensitivity to Noise**	**Yes**	**No**
Vacant Stare/Glassy Eyed	**Yes**	**No**	**Sensitivity to Sound**	**Yes**	**No**
Irritability	**Yes**	**No**	**Nausea/Vomiting**	**Yes**	**No**
Headache	**Yes**	**No**	**Change in Personality**	**Yes**	**No**

Other _____

If there was a loss of consciousness, approximately how long was he/she unconscious? _____

Does student have an altered state of consciousness after the injury? Yes No Unclear

If the student's parents were present at the sporting event, did they assume medical responsibility for their child? Yes No

If no, were the students notified? _____ By whom? _____

Final Action Taken: _____

Evaluator's Signature: _____ Title: _____

Primary Care Physician or Emergency Room Physician Signature: _____

++Please note: The Student is to have a copy of this initial evaluation in their possession if they are transported to the ER for further evaluation and when they report to their primary MD for each office visit. Parents should assume custody of medical form throughout the entire process and return completed form with signatures to the School Nurse.++

HEAD / BRAIN INJURY MANAGEMENT CHECKLIST

To be completed as each step is accomplished.
Do not send home with injured student/athlete!!

Student Name: _____ **Date:** _____

1. Student Initial Concussion Checklist completed	Yes_____	No_____	Initials_____
2. Student Initial Concussion Checklist sent home with student	Yes_____	No_____	Initials_____
3. WCSD Head/Brain Injury Information sent home with student	Yes_____	No_____	Initials_____
4. Physician Evaluation Checklist sent home with student	Yes_____	No_____	Initials_____
5. Student Return to Play/Activity Protocol sent home w/student	Yes_____	No_____	Initials_____
6. Student Initial Concussion Checklist and Physician Evaluation are returned to WCSD nurse within 24 hours after injury	Yes_____	No_____	Initials_____
7. Medical Provider writes a release form for Return to Activity	Yes_____	No_____	Initials_____
8. Student is completely asymptomatic from initial head injury	Yes_____	No_____	Initials_____
9. Student starts the six step *Return to Activity/Play Protocol*	Yes_____	No_____	Initials_____
10. Student completes the *Return to Activity/Play Protocol*	Yes_____	No_____	Initials_____

Graduated Return to Play/Activity Protocol

The program is broken down into six steps in which **only one step is covered per 24-hour period.** If any post-concussion symptoms occur during any of the following steps, the athlete must revert to the previous step. The athlete should rest for 24 hours before attempting to progress again.

1. No Activity: complete physical/cognitive rest	Yes_____	No_____	Initials_____
2. Light Aerobic Activity	Yes_____	No_____	Initials_____
3. Sport Specific Exercise	Yes_____	No_____	Initials_____
4. Non-Contact Training Drills	Yes_____	No_____	Initials_____
5. Full-Contact Practice	Yes_____	No_____	Initials_____
6. Return to Play	Yes_____	No_____	Initials_____

Comments: _____

PHYSICIAN EVALUATION
CONCUSSION CHECKLIST

To be completed by student/athlete's primary care Physician or ER Physician ONLY!

Upon completion, this form must be returned to the Watervliet School Nurse's Office

Student Name _____ Grade _____ Age _____

Date of First Evaluation _____ Time of Evaluation _____

Date of Second Evaluation _____ Time of Evaluation _____

Symptoms Observed	First Doctor Visit		Second Doctor Visit	
Vertigo	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
Photophobia	Yes	No	Yes	No
Sensitivity to Noise	Yes	No	Yes	No
Ante Grade Amnesia	Yes	No	Yes	No
Retro Grade Amnesia	Yes	No	Yes	No

First Doctor Visit--Circle Yes or No for each:

Did you review the "Initial Concussion Checklist" provided by the

School Nurse? Yes No
Did the student sustain a concussion? Yes No
Positive findings on neurological exam? Yes No

Additional Findings / Comments: _____

_____

Recommendations / Limitations: _____

_____

Note: M.D. clearance to participate will trigger the start of WCSD Return to Play Protocol.

Physician's Signature _____ Date _____
Print Physician's Name _____ Phone No. _____

Second Doctor Visit--Please check one of the following:

- ☐ Student is asymptomatic and is ready to begin the return to play/activity progression.
- ☐ Student is still asymptomatic after seven days; must be referred to a concussion specialist/clinic.

Physician's Signature _____ Date _____

Print Physician's Name _____ Phone No. _____