Premier Health

premierhealth.com

Dear Parent:

Your son/daughter has sustained a concussion (or is suspected of having sustained a concussion) during a practice/game. A concussion is a brain trauma (usually mild) that results from a direct blow to the head or a blow to the body that causes a whiplash or rotational type of injury to the head and/or neck. This usually results in a temporary alteration in mental status and does not usually result in a loss of consciousness, although with more serious concussions, it can. Concussions can be serious injuries and our guidelines for treatment have changed over the last few years. We are far more cautious and conservative with the developing brain (ages 5-22) with regard to return to play and evaluation. Your child is currently not qualified for athletic participation. He/she will need a medical evaluation (by a medical doctor, doctor of osteopathic medicine, nurse practitioner (NP), or chiropractor that is registered through the ACBSP Concussion Registry) and clearance will need to be given to participate in a return to play protocol. This return to play protocol is a graduated program of increasing activity over 5 days. This cannot start until the athlete is symptom free and has provided a written note from one of the medical providers previously listed to the athletic trainer.

While your child's symptoms may seem minor, concussion injuries are cumulative and can result in permanent loss of brain function. This is why we have taken a more cautious and graduated approach to return to play after a concussion. Our athletic trainers will work closely with our sports medicine physicians or your child's personal medical provider to ensure a safe return to play.

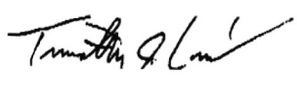
Please help us by following the attached guidelines for concussion care.

Thank you for your assistance and support as we strive to provide your child with the best possible sports medicine care.

Sincerely,

Jeffrey James, DO
Medical Director
The Sports Medicine Center
at Miami Valley Hospital

Mike Barrow, MD
Medical Director
The Sports Medicine Center
at Miami Valley Hospital North



Timothy Linker, MD
Medical Director
AMC Sports Medicine
and Physical Therapy

Jeffrey Rayborn, MD
Medical Director
UVMC Center for
Sports Medicine

Premier Health

GUIDELINES FOR INITIAL CONCUSSION CARE

1. **if your son or daughter has a sudden onset of the following symptoms, please go to an emergency department immediately: increasingly severe headache, repeated vomiting, disorientation, change of personality, seizures, or loss of consciousness.**
2. Have your son or daughter seen by a sports medicine nurse practitioner (NP), or chiropractor that is registered through the ACBSP Concussion Registry with expertise in concussion care or their personal physician. The treating physician needs to be either a medical doctor (MD) or a doctor of osteopathic medicine (DO). Please be completely honest when informing the medical provider of the injury and the symptoms that your child has been exhibiting as well as the symptoms at the time of the injury.
3. You may use acetaminophen (Tylenol) or ibuprofen (advil, Motrin, etc.) to treat the headache. Stronger medications, such as narcotics, should not be used without the express permission of a medical provider that has already evaluated your child.
4. There is no need to waken your child during the night, but you should be observant of any change in their symptoms such as increasing headache, nausea, vomiting, disorientation, or change of personality. These would be reasons to take your child to the Emergency Room.
5. When sleeping, elevation of the head on a couple of pillows may help reduce the headache.
6. Your child is not to be left alone for extended periods of time in the first 24-48 hours.
7. There should be NO exertion, sports, or other physical activity until your child is evaluated by a medical provider AND symptom free.
8. Thought should be given to keeping your child home from school and rescheduling any important tests while your child is still symptomatic. You may want to discuss this with your child's guidance counselor as they may have impaired learning that persists beyond the period of obvious symptoms.
9. Driving should be curtailed as long as your athlete is sumptomatic and until released by the treating medical provider.
10. In order for your child to return to practice and play, please supply the athletic trainer with a written note from the treating physician. This note cannot have a future date set for return to play. You cannot predict when an athlete will be symptom free. The note must be dated on and for the day the athlete can begin the return to play protocol. A follow up appointment may be necessary for this note.
11. Once the athletic trainer has received this note and the athlete is symptom free, the athlete may begin the graduated return to play protocol. This protocol is detailed below. The athlete should check-in daily with the athletic trainer to progress through the stages, and notify athletic trainer or treating medical provider of any symptoms.
12. Please notify the athletic trainer or the treating medical provider of any questions or concerns that you may have.

Please understand that it is our job and goal as the athletic trainer to ensure a safe return to play. The athletic trainer is not trying to unreasonably restrict your child's participation but absolute priority must be given to a safe return when your child and his/her brain are ready to return. While your child may appear normal, brain function generally does not return to normal for several days or weeks following a concussion. No athlete will return to play on same date of injury. This is in accordance with the guidelines put forth by an international symposium of head injury experts, the OHSAA, NCSS, NHSFF, Ohio State law (ORC 3313.539), and Premier Health.

GRADUATED RETURN TO PLAY PROTOCOL		
Rehabilitation Stage	Functional Exercise at Each Stage of Rehab	Objective at Each Stage
1. No activity	Complete physical and cognitive rest	Recovery
2. Light aerobic exercise	Walking, Stationary Bike, Swimming, keeping intensity <70%. No wt training	Increased heart rate
3. Sports specific exercise	Skating drills in ice hockey, running drills in soccer, no head impact activites	Add movement
4. Non contact training drills	Progression to more complex training drills. Passing drills in FB and hockey. Neutral, non marking basketball and soccer drills	Exercise coordination and cognitive load
5. Full contact practice	Normal practice activies	Restore confidence and assess functional skills by coaching staff
6. Return to play	Normal game/competition	

Premier Health

CONCUSSION EVALUATION REPORT

Athlete Name: _____ DOB: _____ Injury Date: _____ Today's Date: _____
Initial Report: _____ School: _____
Parent contact info: _____

A. INJURY DESCRIPTION _____

_____
_____
_____
_____
_____

1. Location of Impact: Frontal _____ Lft Temporal _____ Rt Temporal _____ Lft Parietal _____ Rt Parietal _____
Occipital _____ Neck _____ Face _____

2. Loss of Consciousness: Did you/ person lose consciousness? No ___ Yes ___, Duration _____

3. Early Signs: Appears Dazed/Stunned _____ Confused about events _____ Answers questions slowly _____
Repeats questions _____ Forgetful (recent info) _____

4. PERRLA: Equal Y / N Reactive Y / N Accomodation Y / N If no, explain _____

B. SYMPTOM CHECK LIST *since the injury, has the person experienced any of these symptoms any more than usual?

Indicate presence of each symptom (0=No, 1=Yes)

Headache	0 1	Feeling slowed down	0 1	Sleeping more than usual	0 1
Nausea or Vomiting	0 1	Difficulty concentrating	0 1	Sleeping less than usual	0 1
Feel like "in a fog"	0 1	Difficulty remembering	0 1	Sensitivity to light	0 1
Balance problems	0 1	Visual problems	0 1	Sensitivity to noise	0 1
Dizziness	0 1	Fatigue	0 1	More emotional	0 1
Irritability	0 1	Drowsiness	0 1	Total Symptom Score (0-19)	
Numbness/Tingling	0 1	Trouble falling asleep	0 1		

C. COGNITIVE ASSESSMENT

Orientation: (1 point for each correct answer)

What month is it?	0 1
What is the day of the week?	0 1
What is the date today?	0 1
What year is it?	0 1
What time is it right now?	0 1
Score ___ / 5	

Months in Reverse Order:

Dec-Nov-Oct-Sept-Aug-Jul-Jun-May-Apr-Mar-Feb-Jan	Pass Fail

Recall:

Immediate: (Use 5 random words at the AT's discretion)

Words	Trial 1	Trial 2	Trial 3
_____	0 1	0 1	0 1
_____	0 1	0 1	0 1
_____	0 1	0 1	0 1
_____	0 1	0 1	0 1
_____	0 1	0 1	0 1
Score ___ / 5			

Delayed:

Trial 4 | Repeat a single trial at the end of exam.

Score ___ / 5

Attention:

Digits Sequence

List	Trials	
4-9-3	Pass	Fail
3-8-1-7	Pass	Fail
6-2-9-7-1	Pass	Fail

Balance:

Rhomberg's Test:	Pass	Fail
Arm Drift:	Pass	Fail

D. ASSESSMENT _____

_____

E. PLAN _____

_____
_____

AT Signature _____ Medical Provider _____

Premier Health

CONCUSSION EVALUATION REPORT

Athlete Name: _____ DOB: _____ Injury Date: _____ Today's Date: _____
Initial Report: _____ School: _____
Parent contact info: _____

A. INJURY DESCRIPTION _____

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_____
_____
_____
_____

1. Location of Impact: Frontal _____ Lft Temporal _____ Rt Temporal _____ Lft Parietal _____ Rt Parietal _____
Occipital _____ Neck _____ Face _____

2. Loss of Consciousness: Did you/ person lose consciousness? No ___ Yes ___, Duration _____

3. Early Signs: Appears Dazed/Stunned _____ Confused about events _____ Answers questions slowly _____
Repeats questions _____ Forgetful (recent info) _____

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Balance problems	0 1	Visual problems	0 1	Sensitivity to noise	0 1
Dizziness	0 1	Fatigue	0 1	More emotional	0 1
Irritability	0 1	Drowsiness	0 1	Total Symptom Score (0-19)	
Numbness/Tingling	0 1	Trouble falling asleep	0 1		

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What is the date today?	0 1
What year is it?	0 1
What time is it right now?	0 1
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Months in Reverse Order:

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_____	0 1	0 1	0 1
_____	0 1	0 1	0 1
_____	0 1	0 1	0 1
Score ___ / 5			

Delayed:

Trial 4 | Repeat a single trial at the end of exam.

Score ___ / 5

Attention:

Digits Sequence

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Balance:

Rhomberg's Test:	Pass	Fail
Arm Drift:	Pass	Fail

D. ASSESSMENT _____

_____

E. PLAN _____

_____
_____

AT Signature _____ Medical Provider _____

Premier Health

GRADUATED RETURN TO PLAY PROTOCOL FOR HEAD INJURIES

The stepwise progression outlines below allows a reasonable process for returning to sport and allowing for assessment of each step. The athlete should be able to progress to the next level if they are asymptomatic at the current level. Generally each step should take 24 hours to complete. If any post concussive symptoms occus while in the stepwise program, the athlete should drop back to the previous asymptomatic level, rest for 24 hours, and then try to progress again from the asymptomatic level.

- Medical provider documentation of clearance to begin RTP protocol must be attached to this form.

Rehab Stage/ Date Completed	Functional Exercises Performed at Each Stage of Rehab	Symptoms	Supervisor
1. No Activity	Complete physical and cognitive rest **Objective: Recovery**		
2. Light Aerobic Exercises	Walking, Light Stationary Biking Stretching, No Resistance Training Limit Head Movement/ Limit Concentration Activites Non Risk/ Light Aerobic Exertion only Keeping Intensity 30-40% normal Total Time = <30 min. Other: _____ **Objective: Increase Heart Rate**		
3. Sport Specific Exercise	Stationary Biking, Jogging Running Drills, Sit-Ups, Push-Ups, Lunges No Head Impact Activities, Baseball/ Softball Throwing Basketball: Foul Shots No Resistance Training Allow Head Movement & Low Concentration Activity (i.e. counting repetitions) Non Risk/ Moderate Aerobic Exertion Keeping Intensity 40-60% normal Total Time = 30-60 min. Other: _____ **Objective: Add Movement**		
4. Non-contact Training Drills	Progression to more non-contact complex drills Plyometrics, Running/ Sprinting Football: Sled Work, Passing Drills, Running Routes Soccer: Shooting on Goal, Agility Dribbling Drills Basketball: Shooting Drills, Ball Handling Drills May Start Resistance Training Keeping Intensity 60-80% normal Moderate to Aggressive Aerobic Exertion Total Time = 60-120 min. Other: _____ **Objective: Coordination & Cognitive Load**		
5. Full Contact	Normal Practice Activites Intensity: Full Exertion **Objective: Restore Confidence & Assess Function Skills**		
6. Return to Play	Normal Game/ Competition		

Ohio High School Athletic Association
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PH: 614-267-2502; FAX:614-267-1677
ohsaa.org

MEDICAL AUTHORIZATION TO RETURN TO PLAY WHEN A STUDENT HAS BEEN REMOVED DUE TO A SUSPECTED CONCUSSION

Ohio State Law as well as NFHS rules and OHSAA policy require a student who exhibits signs, symptoms or behaviors associated with concussion to be removed from a practice or contest and **not permitted to reenter practice or competition on the same day as the removal**. Thereafter, **written medical authorization from a physician (M.D. or D.O.)** or another qualified licensed medical provider, who works in consultation with, collaboration with or under the supervision of an M.D. or D.O. or who is working pursuant to the referral by an M.D. or D.O., AND is authorized by the Board or Education or other governing board, **is required to grant clearance for the student to return to participation**. This form shall serve as the authorization that the physician or licensed medical professional has examined the student, and has cleared the student to return to participation. The physician or licensed medical professional must complete this form and submit to a school administrator prior to the student's resumption of participation in practice and/or a contest. **To reiterate, this student is not permitted to reenter practice or competition on the same day as the removal.**

I, _____, M.D., D.O. or _____(other qualified licensed medical provider) have examined the following
(Print name of MD, DO or Other)
student, _____ from _____High School/7-8th grade school
(Name of Student),
who was removed from a _____(sport) contest at the _____level (V, JV, 9th, 7-8th) due to exhibition of signs/symptoms/behaviors consistent with a concussion. I have examined this student, and determined that the student is cleared to resume participation upon the completion of the directions provided below.

PLEASE INDICATE YOUR DIRECTIONS BELOW

___Return to play protocol for concussion as outlined in Zurich Consensus Statement 2012 or as attached.

___Return to play protocol for concussion required under direction of Licensed Athletic Trainer or other qualified Licensed medical provider as approved in above directive

___Return to play protocol for concussion not required, and the student may return to participation in practice and competition on this date_____

___Return to play clearance is limited to the following sport(s): _____

___Other: (explain):

VALID ONLY WITH ALL INFORMATION COMPLETED

Signature of Medical Professional _____
(MD, DO or other qualified Licensed Medical Provider as Approved in the Above Directive)

Date: _____

Contact Information: _____

(Print or Stamp) Address: _____

Phone: _____

Return to play is also subject to clarification of this document, as deemed necessary, by Licensed Athletic Trainer, other qualified Licensed medical providers authorized by Board of Education or other governing body, or school district administration. Return to play decisions are also subject to recognized principles of conditioning, skill development, mental preparedness, etc.

Parent(s)/Guardian and student are reminded that the initial signature document of awareness of signs and symptoms of concussion and need/requirement to report are still in effect. Parent(s)/Guardian and student have a responsibility to report any further signs or symptoms of a concussion or head injury to coaches, administrators and the student- athlete's doctor. Information regarding signs and symptoms are available from school district personnel or OHSAA website.

PRESENT THIS FORM TO THE SCHOOL ADMINISTRATOR

Note: The school must retain this form indefinitely as a part of the student's permanent record. Medical Providers should retain a copy for their own records.