

Schertz-Cibolo-Universal City Independent School District

CONCUSSION PROTOCOL



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What is a concussion?

A concussion is an injury to the brain. It is caused by a bump, blow, or jolt to either the head or the body that causes the brain to move rapidly within the skull. The resulting injury to the brain changes how the brain functions in a normal manner. The signs and symptoms of a concussion can show up immediately after the injury or may not appear for hours or days after the injury. Concussions can have serious long-term health effects, and even a seemingly mild injury can be serious. A major concern with any concussion is returning to play too soon. Having a second concussion before healing can take place from the initial or previous concussion can lead to serious and potentially fatal health conditions.

What are the symptoms of a concussion?

Signs and symptoms of a concussion are typically noticed right after the injury, but some might not be recognized until days after the injury. Common symptoms include: headache, dizziness, amnesia, fatigue, confusion, mood changes, depression, poor vision, sensitivity to light or noise, lethargy, poor attention or concentration, sleep disturbances, and aggression. The individual may or may not have lost consciousness.

What should be done if a concussion is suspected?

Immediately remove student from practice or game

1. Seek medical attention right away
2. Do not allow the student to return to play until proper medical clearance and return to play guidelines have been followed. The permission for return to play will come from the appropriate health care professional or professionals.

What should the athlete know about playing with a concussion?

Teach athletes it's not smart to play with a concussion. Rest is the key after a concussion. Sometimes athletes, parents, and other school or league officials wrongly believe that it shows strength and courage to play injured. Discourage others from pressuring injured athletes to play. Don't let your athlete convince you that they're "just fine."

What are the risks of returning to activity too soon after sustaining a concussion?

Prevent long-term problems. If an athlete has a concussion, their brain needs time to heal. Don't let them return to play the day of the injury and until a health care professional, experienced in evaluating for concussion, says they are symptom-free and it's OK to return to play. A repeat concussion that occurs before the brain recovers from the first—usually within a short time period (hours, days, weeks)—can slow recovery or increase the chances for long-term problems.

What can happen if my child keeps on playing with a concussion?

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 under report symptoms of injuries. And concussions are no different. As a result, education of administrators, coaches, parents and students is the key for student-athlete's safety.

Liability Provisions

The student and the student's parent or guardian or another person with legal authority to make medical decisions for the student understands this policy does not:

1. waive any immunity from liability of a school district or open-enrollment charter school or of district of charter school officers or employees;
2. create any liability for a cause of action against a school district or open-enrollment charter school or against district or charter school officers or employees;
3. waive any immunity from liability under Section 74.151, Civil Practice and Remedies Code;
4. create any liability for a member of a concussion oversight team arising from the injury or death of a student participating in an interscholastic athletics practice of competition, based only on service on the concussion oversight team.

Home Instructions for Concussions

(Name) _____ has sustained a possible concussion during (Sport) _____, on ____/____/____.

To make sure he/she recovers please follow the following important recommendations:

1. Please watch for the following:

SYMPTOMS DESCRIBED BY ATHLETE

Headache
Nausea
Balance problems or dizziness
Double or fuzzy vision
Sensitivity to light or noise
Feeling sluggish
Feeling foggy or groggy
Concentration or memory problems
Confusion

SIGNS OBSERVED BY PARENTS, TEACHERS OR COACHES

Appears dazed or stunned
Is confused about what to do
Forgets plays
Is unsure of game, score, or opponent
Moves clumsily
Answers questions slowly
Loses consciousness
Shows behavior or personality changes
Can't recall events prior to hit
Can't recall events after hit

2. Things that are OK to do:

- Take acetaminophen once at the beginning of impact
- Use ice packs on head or neck as needed for comfort
- Wake up every 2 to 3 hours (make sure they are alert and can answer questions)
- Eat a light diet
- Go to sleep (rest is very important)
- No strenuous activity or sports
- Return to school

3. Things that should not be allowed:

- Eat spicy foods
- Watch TV
- Listen to iPod or talk on telephone
- Read
- Use a computer
- Bright lights
- Loud noise
- Drink alcohol

4. Things there is no need to do:

- Check eyes with a flashlight
- Test reflexes

c. Further recommendations:

Report to the Athletic Training Room or school nurse (Jr. High only) tomorrow for a follow-up.

Instructions provided to: _____

Given by: _____

Date: _____ Time: _____



Post-Concussion Symptom Scale

Name _____ Date RTP Started _____

The student should rate each symptom the first 3 days of the RTP Protocol. The student should have zero's each day to start progression or progress to the next day. (attach another sheet if necessary)

	Day 1: / /	Day 2: / /	Day 3: / /	Day 4: / /	Day 5: / /
Symptoms	None Mild Severe	None Mild Severe	None Mild Severe	None Mild Severe	None Mild Severe
Headache/Pressure in Head	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Nausea	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Vomiting	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Balance Problems	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Dizziness	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Feeling Tired	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Trouble falling asleep	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Sleeping more than usual	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Sleeping less than usual	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Drowsiness	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Light Sensitivity	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Noise Sensitivity	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Sadness	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Nervous	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Feeling more emotional	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Numbness or tingling	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Feeling Slowed down	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Does not "Feel Right"	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Difficulty concentrating	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Difficulty remembering	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Difficulty Thinking Clearly	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Blurred/Double vision	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
STAFF USE ONLY: Asymptomatic After Exercise (Circle One & Initial)	Yes No Int:_____	Yes No Int:_____	Yes No Int:_____	Yes No Int:_____	Yes No Int:_____

Must be initialed by a member of the CP team every day to advance

Staff Athletic Trainer's will supervise the progression of High School athletes. Junior High students will report to the school nurse, and will be supervised by the coaching staff. The student must report to the school nurse for compliance each day.

Medical Provider's Form

Concussion Management Information

Dear Medical Provider,

_____ (name of patient) has sustained a head injury on _____ (date of injury) believed to be a concussion. This patient is an interscholastic athlete who is governed by the HB2038 or Natasha's Law. The requirements for the student to return to athletic participation are an evaluation and clearance by a Physician, clearance by the school's Athletic Trainer (or other licensed health care professional) after completion of the stages of exertion and written acknowledgment by the athlete and the parent/guardian. The athlete will progress through progression of exertion under the school's Athletic Trainer (or other licensed health care professional). Below is the outline of the progression of exertion.

The athlete will not progress to the next day if he/she is not asymptomatic. If the athlete cannot complete the 5 step progression in 7 consecutive school days, they will need to return to the doctor for a second evaluation

Step 1: Light aerobic activity (10-15 minutes) & gravity changes.

Step 2: Moderate aerobic activity (15-20 minutes) & gravity changes.

Step 3: Heavy Exertion without contact including lifting weights.

Step 4: Full contact practice including lifting weights.

Step 5: Full practice or competition.

Permission to Return to Activity

Patients Name: _____ DOB: _____

The athlete named above is cleared for a complete return to full contact sports participation after :

_____ Completing the concussion return-to-play protocol, including progression of exertion, without recurrence signs or symptoms

_____ Pending a follow-up examination after completing progression of exertion.

This athlete needs Academic Accommodations until released to full activity or _____(date).

___Unlimited tests ___No exams ___Extended time on homework ___Reduced Assignments ___Printed class notes

Printed Physicians Name: _____ Clinic Phone Number _____

Signature or Physician: _____ Date: _____

Concussion Management Protocol Return to Play Form

This form must be completed and submitted to the athletic trainer or other person (who is not a coach) responsible for compliance with the Return to Play protocol established by the school district Concussion Oversight Team, as determined by the superintendent or their designee (see Section 38.157 (c) of the Texas Education Code).

Student Name (Please Print)

School Name (Please Print)

Parent or other person with legal authority to make medical decisions for the student signs and certifies that he/she:

Please Check

- _____ Has been informed concerning and consents to the student participating in returning to play in accordance with the return to play protocol established by the Concussion Oversight Team.
- _____ Understands the risks associated with the student returning to play and will comply with any ongoing requirements in the return to play protocol.
- _____ Consents to the disclosure to appropriate persons, consistent with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), of the treating physician's written statement under Subdivision (3) and, if any, the return to play recommendations of the treating physician.
- _____ Understands the immunity provisions under Section 38.159 of the Texas Education Code.

Parent/Responsible Decision-Maker Signature

Date

Parent/Responsible Decision-Maker Name (Please Print)

Designated school district official verifies:

Please Check

- _____ The student has been evaluated by a treating physician selected by the student, their parent or other person with legal authority to make medical decisions for the student.
- _____ The student has completed the Return to Play protocol established by the school district Concussion Oversight Team.
- _____ The school has received a written statement from the treating physician indicating, that in the physician's professional judgment, it is safe for the student to return to play.

School Individual Signature

Date

School Individual Name (Please Print)