EAST IRONDEQUOIT CENTRAL SCHOOL DISTRICT

CONCUSSION PARENT PACKET

Initial Concussion Checklist

Name:_____ Age:_____ Grade: _____ Sport:_____

Date of Injury:_____ Time of Injury:_____

Description of Injury:_____

_____

_____

Has the athlete ever had a concussion?	Yes	No	If yes, date:_____
Was there a loss of consciousness?	Yes	No	Unclear
Does he/she remember the injury?	Yes	No	Unclear
Does he/she have confusion after the injury?	Yes	No	Unclear

Symptoms observed at time of injury: * Please circle yes or no for each symptom listed.

Dizziness	Yes	No	Headache	Yes	No
Ringing in Ears	Yes	No	Nausea/Vomiting	Yes	No
Drowsy/Sleepy	Yes	No	Fatigue/Low Energy	Yes	No
"Doesn't Feel Right"	Yes	No	Feeling "Foggy"	Yes	No
Numbness or Tingling	Yes	No	Balance Problems	Yes	No
Memory Problems	Yes	No	Loss of Orientation	Yes	No
Blurred Vision	Yes	No	Sensitivity to Light	Yes	No
Vacant Stare	Yes	No	Sensitivity to Noise	Yes	No
Emotionality	Yes	No	Irritability	Yes	No

Other Findings/Comments: _____

Final Action Taken: Parents Notified Sent to Hospital

Evaluator's Signature:_____ Title:_____

Date:_____ Phone No.: _____

** **Submit this form to Athletic Trainer****

EAST IRONDEQUOIT CENTRAL SCHOOL DISTRICT

Home Instructions

_____ has/may have sustained a concussion during _____ today. In some instances, the signs of a concussion do not become obvious until several hours or even days after the injury. Please be especially observant for the following signs and symptoms.

1. Headache (especially one that increases in intensity*)
2. Nausea and vomiting*
3. Mental confusion/behavior changes
4. Dizziness
5. Memory loss
6. Ringing in the ears
7. Changes in gait or balance
8. Blurry or double vision*
9. Slurred speech*
10. Changes in the level of consciousness (difficulty awakening, or losing consciousness)*
11. Seizure activity*
12. Decreased or irregular pulse OR respiration*

*** Seek medical attention at the nearest emergency department**

Things that are OK to do:	**Things that are NOT allowed:**	**Things that are not needed:**
Take acetaminophen (Tylenol)	Physical activity/Driving	Check eyes with a flashlight
Use ice packs on head or neck as needed for comfort	Watch TV, Video Games	Wake up every hour
Eat a light diet	Listen to Ipod or use phone	Test reflexes
Go to sleep (if symptoms have stabilized or resolved)	Use a computer /Excessive reading	
Return to school (If feeling up to it)	Bright lights/Loud Noise	

If your Son/Daughter is seen by a Physician, you **MUST** have the Head Injury Referral Form (Page 3) completed and signed. Have student report to school nurses office when returning to school for follow-up exam. If you have non-emergent questions, contact the Athletic Trainer, Jarett Rhoads @ (585) 451-9105

Further recommendations: _____

Instructions provided by: _____

Date: _____ Time: _____ Contact Number: _____

EAST IRONDEQUOIT CENTRAL SCHOOL DISTRICT

Head Injury Referral Form

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

Name of Athlete: _____

Date of First Evaluation:_____ **Time of Evaluation:_____**

Date of Second Evaluation: _____ **Time of evaluation:_____**

***PLEASE INDICATE YES OR NO IN YOUR RESPECTIVE COLUMNS.**

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: **(one or the other must be circled)**

Did you review the "Initial Concussion Checklist" provided by the Athletic Trainer or Coach/Nurse?	Yes	No
Did the student sustain a concussion?	Yes	No
Positive finding on neurological exam?	Yes	No

Additional Findings/Comments:_____

_____

Recommendations/Limitations:_____

_____

Physician's Signature:_____ Date: _____

Print Physician's Name:_____ Phone Number:_____

Second Doctor Visit:

Please check one of the following:

- ☐ Student is asymptomatic and may begin the return to activity progression/ImPACT Testing.
- ☐ Student is still symptomatic after seven days. Refer to a concussion specialist/clinic.

Physician's Signature:_____ Date:_____

Print Physician's Name:_____ Phone Number:_____

Return To Play Guidelines

At the direction of our school physician, WorkFit Medical, LLC and our Concussion Management Team, the East Irondequoit Central School District follows the concussion guidelines set forth by the NYSPHSAA and New York State Law as follows:

Any time during practice or competition that a student-athlete experiences any sign(s)/symptoms(s) of a concussion he/she will not be permitted to return to play/practice that day. Proper evaluation and follow-up must be completed by the Athletic Trainer.

❖ **Students injured with a concussion may return to play athletics and physical education when he/she meets the following criteria:**

1. Initial evaluation by Physician*.
2. Asymptomatic for 24 hours.
3. Ability to tolerate a full day of school without symptoms returning.
4. Second medical clearance to commence the Return to Play Progression (see below).
5. Successful completion of the Return to Play Progression.
6. ImPACT scores return to within normal limits of baseline (if applicable).
7. Final medical clearance to return to full contact.

Physicians evaluating concussed athletes should be "trained in the evaluation and management of concussions." Physician clearance notes inconsistent with the concussion policy will not be accepted and such matters will be referred to our school physician.

Return to Play Progression

We follow a stepwise activity progression based on recommendations from the Berlin Consensus Statement, 5th International Conference on Concussion in Sport, 2016 as follows:

Stage 0: Rest and/or symptom-limited activity until symptom-free (asymptomatic)
Stage 1: Light aerobic exercise (i.e. walking/jogging, stationary bike, elliptical-15 minutes)
Stage 2: Higher impact, sport specific non-contact activity (i.e. jogging/running, jumping rope, sport specific exercise-30 minutes). No resistance training.
Stage 3: Sport specific non-contact drills (i.e. increase running intensity, sport-specific drills- 45-60 minutes). Low resistance training with a spotter. Post-injury ImPACT test
Stage 4: Full contact practice activities. High resistance training with a spotter.
Stage 5: Final Clearance by District Physician and Athletic Trainer, cleared for return to play

Each stage should take 24 hours so that an athlete would take approximately one week to proceed through the full rehabilitation protocol once they are asymptomatic at rest and with provocative exercise. If any post-concussion symptoms occur while in the stepwise program, then the student should drop back to the previous asymptomatic level and try to progress again after a further 24 hour period of rest has passed.

ImPACT Testing (www.impacttest.com)

Eastridge High School currently uses ImPACT® (Immediate Post Concussion Assessment and Cognitive Testing) software to assist in the management of head injuries. The 20-30 minute, computer based program tracks neurocognitive information such as memory, reaction time, brain processing speed and concentration. We administer a post-concussion test 24-72 hours after injury, and we continue to re-test until their scores return to within normal limits. **ImPACT is an assessment tool and should not be confused with or considered a clearance.** All students are baseline tested during the first week of school in their Physical Education and Dance classes.