Department of Health, Physical Education and Athletics

Spencer-Van Etten School District
P.O. Box 307, 16 Dartts Crossroads
Spencer, New York 14883

Spencer-Van Etten Central Schools – 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 tomorrow 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 to 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 within the greater Central New York area and the Spencer-Van Etten Central School's Supervising Medical Officers and concussion management team. As such, it is imperative to remember the safety of the student is the primary concern of the Spencer-Van Etten 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, medical personnel or athletic trainer 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 by an Emergency Department within the first 24 hours.
4. The student **must have** the "Student/Athlete Initial Concussion Checklist by Athletic Trainer, Coach or Nurse" and the "Concussion Checklist Physician Evaluation" signed and dated by #3 above. These forms **must be** returned to either the Athletic Trainer or School Nurse at the Spencer-Van Etten Central Schools.
5. Return to play **must follow** a medical clearance and successful completion of the "Return to Play Protocol."
6. The School Nurse or Athletic Trainer will supervise and document the Zurich Guidelines. The School District appointed M.D. has final determination for students 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, upon completion must return to the diagnosing physician for clearance to participate in contact drills.
5. Begin, "controlled contact," where the athlete starts doing light contact but not full practice.
6. Full contact training in practice setting (if a contact/collision sport).
7. 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.

Student/Athlete Initial Concussion Checklist

To be filled out by Athletic Trainer, Coach or Nurse

Original copy must be returned to the Spencer-Van Etten School Athletic Director

Student Name: _____ Age: _____Sport: _____ Date of Injury: _____

Student Parents' Name: _____ Location of sporting event: _____

Student Parents' Phone Number: H ( ) - _____W ( ) - _____ C ( ) - _____

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 were they 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 parents notified? By whom?_____

Final Action Taken: _____

Evaluator's Signature:_____ Title:_____

Primary Care Physician or Emergency Room Physician Signature:**(This MUST be a MD or DO 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*****

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 Spencer-Van Etten School Nurse's Office

Student Name_____ Grade_____ Age_____

Date of First Evaluation:_____ Time of Evaluation:_____

Date of Second Evaluation:_____ Time of Evaluation:_____

*PLEASE INDICATE YES OR NO IN YOUR RESPECTIVE COLUMS.
Symptoms Observed:

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, Coach or 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 SVECSD's Return to Play Protocol.

Physician's Signature_____ Date_____

Print Physician's Name_____ Phone Number_____

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 symptomatic after seven days, must be referred to a concussion specialist/clinic.

Physician's Signature_____ Date_____
Print Physician's Name_____ Phone Number_____

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. SVE 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 with student: Yes___ No___ Initials____
6. Student Initial Concussion Checklist and Physician Evaluation are returned to S-VE nursing staff 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 Play/Activity Protocol: Yes___ No___ Initials____
10. Student completes the Return to Play/Activity 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 one 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: