,

CHITTENANGO CENTRAL SCHOOLS STUDENT INITIAL CONCUSSION CHECKLIST

BY ATHLETIC TRAINER OR COACH/NURSE

Updated 07/01/12

Student's Name:_____(H) # (315) _____(C)#(315)_____

Parents' Name:_____(H) # (315)_____(C)#(315)_____

Age:____Grade____Sport:_____Date of Injury:_____Time of Injury:_____(W)#(315)_____

Location of sporting event where injury occurred:_____

Description and nature of Injury:_____

SYMPTOMS OBSERVED OR REPORTED AT TIME OF INJURY:

*__Please circle yes or no for each symptom listed below.__

Dizziness	Yes	No	Nausea/Vomiting	Yes	No
Ringing in Ears	Yes	No	Fatigue/Low Energy	Yes	No
Drowsy/Sleepy	Yes	No	Feeling "Dazed"	Yes	No
"Don't Feel Right"	Yes	No	Poor Balance/Cord.	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	Retro Grade Amnesia	Yes	No
Headache	Yes	No	Change in Personality	Yes	No

Other_____

Yes No Unclear Has Student sustained a prior concussion? *IF "**Yes**", Indicate date:*_____
*Severity and treatment of prior Concussion:*_____

Yes No Unclear Was there any loss of consciousness? *IF **"yes"**, How Long?* _____
Yes No Unclear Does Student remember the injury?
Yes No Unclear Does Student have an altered state of consciousness after the injury?
Yes No Are or were the Student's Parents at the sporting event at the time of injury?
Yes No *IF **"yes",** did they assume medical responsibility for their child?*
Yes No *IF **"no",** were the parents notified? By whom)*_____

Additional findings/comments:_____

Final Action Taken:_____

(Please note the Student is to have 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 signature to Trainer or Nurse)

Initial Evaluator's Signature:_____Title:_____Date:_____

Address:_____Phone No.:_____

ER Attendant Signature:_____Print Name:_____

Primary M.D. Signature:_____Print Name: _____

CHITTENANGO CENTRAL SCHOOLS
CONCUSSION CHECKLIST
Physician Or E.R. Evaluation

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

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 COLUMNS.**

Symptoms Observed:	**First Doctor/E.R. 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:_____

_____

NOTE: M.D. clearance to participate trigger the start of B.C.S.'s return to play procedure.

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_____

CHITTENANGO CENTRAL SCHOOLS
STUDENT
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, Prague 2004. In addition it has been fabricated in a collaborative effort with concussive experts within the greater Central New York area and the Chittenango Central School's concussion management team. As such it is imperative to remember the safety of the student is the primary concern of Chittenango 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 concussive event. This information is ***not to be considered as all inclusive or all encompassing.***

When a Student shows signs or symptoms of a concussion or is suspected to have sustained a brain injury after an evaluation by 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 initial few 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 "initial Concussion Checklist by Athletic Trainer or Coach/Nurse" and the "Concussion Checklist Physician Evaluation" signed and dated by #3 above. These forms must be returned to either Athletic Trainer or School Nurse at Chittenango Central Schools.
5. Return to play **must follow** a medical clearance and successful completion of the "return to Play Protocol."
6. The Athletic Trainer will supervise and document the Prague "Return to Play Protocol." 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 involve with the Return to Play Protocol are:

1. No exertion activity until asymptomatic.
2. Light aerobic exercise such as walking or stationary bike, etc. No resistance training.
3. Sport/activity specific exercise such as skating, running, etc. Progressive addition of resistance training may begin.
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.