# Concussion Management Form for the Medical Professional

This form is to be completed by a licensed health care provider. Providers are encouraged to review the CDC website if they have questions regarding the latest information on the evaluation and care of the youth athlete following a concussion injury.

| YOUTH ATHLETE'S NAME | | DATE | SPORT |
|---|---|---|---|
| DATE OF BIRTH | AGE | SCHOOL/TEAM | |

REPORTER ☐ PATIENT ☐ PARENT ☐ CAREGIVER(S) ☐ SIBLING(S) ☐ FIRST RESPONDER ☐ COACH ☐ OTHER:

## *INJURY CHARACTERISTICS*

**Date/Time of Injury:**

***Injury Description:***

Location of Impact: ☐Lt Frontal ☐Rt Frontal ☐Lt Parietal ☐Rt Parietal ☐Occipital ☐ Crown ☐ Neck ☐ Indirect Force

Are there any events just BEFORE the injury that you have no memory of? ☐YES ☐NO

Are there events just AFTER the injury that you have no memory of? ☐YES ☐NO

Loss of Consciousness: ☐YES ☐ NO If yes, for how long? Seizures: ☐ YES ☐ NO

Initial Signs: ☐dazed or stunned ☐confused about events ☐answered questions slowly ☐repeated questions ☐forgetful

## *SYMPTOM CHECKLIST - Since the injury has the person experienced any of these symptoms?*

| PHYSICAL | | COGNITIVE | | SLEEP | |
|---|---|---|---|---|---|
| Headache | Yes \| No | Confusion | Yes \| No | Drowsiness | Yes \| No |
| Nausea | Yes \| No | Feeling slowed down | Yes \| No | Sleeping less than usual | Yes \| No |
| Vomiting | Yes \| No | Difficulty concentrating | Yes \| No | Sleeping more than usual | Yes \| No |
| Balance problems | Yes \| No | Difficulty remembering | Yes \| No | Trouble falling asleep | Yes \| No |
| Dizziness | Yes \| No | EMOTIONAL | | Exertion: Do symptoms worsen with: | |
| Visual problems | Yes \| No | Irritability | Yes \| No | Physical Activity? | ☐ YES ☐ NO |
| Fatigue | Yes \| No | Sadness | Yes \| No | | |
| Sensitivity to light | Yes \| No | More emotional | Yes \| No | | |
| Sensitivity to noise | Yes \| No | Nervousness | Yes \| No | Cognitive Activity? | ☐ YES ☐ NO |
| Numbness | Yes \| No | | | | |

***Refer to the emergency department with sudden onset of any of the following:***

* Headaches that worsen
* Seizures
* Focal neurologic signs
* Looks very drowsy/can't be awakened
* Repeated vomiting
* Slurred speech
* Can't recognize people or places
* Increasing confusion or irritability
* Weakness or numbness in arms/legs
* Neck pain
* Unusual behavioral change
* Change in state of consciousness

## *RETURN TO SPORTS*

- Athletes are not allowed return to practice or play the same day that their head injury occurred.
- Athletes should never return to play or practice if they still have ANY symptoms.
- More than one evaluation is typically necessary for medical clearance for concussion as symptoms may not fully present for days.
- Due to the need to monitor concussions for recurrence of signs & symptoms with cognitive or physical stress, Emergency Room and Urgent Care physicians typically do not make clearance decisions at the time of the first visit.

## *MEDICAL PROVIDER RETURN TO SCHOOL/PLAY RECOMMENDATIONS* - This return to school/play is based on today's evaluation.

☐ Do not return to school

☐ Return to School on _____

☐ No Academic Modifications Needed

☐ Academic Modifications Needed (Complete Return to School Form)

☐ No activity or sports restrictions are necessary.

☐ No sports practice, physical education, or competition at this time.

☐ May start return to play progression under the supervision of the health care provider. (Complete Return to Play Form)

☐ Must return to medical provider for final clearance to return to competition

| LICENSED HEALTH CARE PROVIDER NAME | SPECIALTY (CIRCLE ONE) MD DO Neuropsychologist PA APN Other: |
|---|---|
| OFFICE ADDRESS | SIGNATURE |
| PHONE NUMBER | DATE |

This information is provided in accordance with the guidance found in Act 1435 of the 2013 Arkansas General Assembly.

## Post-Concussion Graduated Return to Play Protocol: Medical Release Form

Name _____ Date of Birth_____ Age_____ Date of Injury_____

Injury Details_____

_____

**Instruction**: Student is cleared to initiate and proceed through the protocol as detailed below after a full day of normal activity with **no symptoms of concussion**. Follow the gradual and progressive steps of the training sequence below. There should be at least 24 hours between each step. If *any* symptoms return at any time during these activities, stop the workout. Rest until symptom free for 24 hours then return to the previous asymptomatic step. If symptoms return or worsen, seek medical attention.

I, _____ (Please print: Licensed Health Care Provider Name, Medical Specialty), release this athlete to begin the Post-Concussion Graduated Return to Play Protocol described below on _____ (Date). Signature: _____

This protocol will be administered by _____ (Name and Title). I will follow up upon successful completion of this protocol before full medical clearance to return to play.

**Graduated Return to Play Protocol – Supervised by Licensed Healthcare Provider**

| STEP | DATE COMPLETED | ACTIVITY | COMMENTS |
|---|---|---|---|
| 1. Light general conditioning exercises (Goal: Increase heart rate). | | *Begin with sport specific warmup. Do 15-20 minute workout: stationary bicycle, fast paced walking or light jogging, rowing or freestyle swimming<br>*Attend full day of school if in session. | |
| 2. Moderate general conditioning and sport specific skill work; individually (Goal: add movement, individual skill work). | | *Sport-specific warm-up. Slowly increase intensity and duration of workout 20-30minutes. Begin sport specific skill work within the workout. No spins, dives or jumps.<br>*Attend full day of school if in session. | |
| 3. Heavy general conditioning, skill work; individually & with teammate. NO CONTACT.<br>(Goal: Add movement, teammate skill work). | | *Continue with general conditioning up to 60 minutes. Increase intensity and duration. Begin interval training.<br>-Continue individual skill work.<br>-Begin skill work with partner-no contact.<br>-Continue with individual skill work as in Step 2.<br>*Attend full day of school if in session. | |
| 4. Heavy general conditioning, skill work and team drills. No live scrimmages. VERY LIGHT CONTACT (Goal: Team skill work, light static contact). | | *Resume regular conditioning and duration of practice. -Increase interval training and skill work as required -Gradually increase skill level of spins, dives, jumps -Review team plays with no contact.<br>-Very light contact and low intensity on dummies *Attend full day of school if in session. | |
| 5. Full team practice with body contact | | *Participate in a full practice. If a full practice is completed, discuss with the coach about getting back in next game.<br>*Attend full day of school if in session. | |

**I verify Graduated Return to Play Protocol has been successfully completed.**

**Licensed Health Care Provider Signature: _____ Date: _____**

# Return to Learn: Concussion Clearance Form

To be completed by a nurse or other school official

**Youth Athlete's Name**_____ **Date of Birth** _____

**School/Organization**_____ **Team/Sport** _____

## Returning to School

Following an injury it is important for the student to return to learning or school when they are physically capable. Careful steps should be followed to safeguard the health of the young person and to ensure that they are able to complete the work. A student may not be allowed to return until after being cleared by a healthcare provider, but this is not always the case.

In some cases the student is able to return for partial or full days long before returning to any sport or activity. It is important for the school to make adjustments for the student to compensate for the injury.

## Steps before Returning to Learn

1. Assess the students needs.
2. Create an intervention plan.
3. Monitor the plan.
4. Make adjustments until the student no longer needs help.

**Physician's name** (If a doctor is involved): _____ **Date**_____

**School nurse or other responsible school official**: _____ **Date**_____

**Parent or Legal Guardian**: _____ **Date**_____

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# Return to Learn: Concussion Clearance Form

To be completed by a nurse or other school official

| Symptoms and Appropriate Interventions | Expected period of time for intervention: |
|---|---|
| Physical symptoms (such as headache, nausea, dizziness, blurred or painful vision, sensitive to noise, neck pain, etc.) | |
| ☐ Scheduled breaks, rest periods | |
| ☐ Quiet room/environment | |
| ☐ Additional breaks from classroom | |
| ☐ No PE/recess/activity | |
| ☐ Use of sunglasses | |
| Cognitive symptoms (such as trouble concentrating, difficulty with memory, mentally foggy, slow processing, etc.) | |
| ☐ Classroom and Homework reduction | |
| ☐ Extended assignment due dates | |
| ☐ Exempt/postponed tests | |
| ☐ Extra time | |
| ☐ No PE/recess/activity | |
| Emotional symptoms (such as trouble controlling emotions or being upset, sad, nervous, or angry) | |
| ☐ Quick signal between teacher and student | |
| ☐ Inform staff that student could breakdown | |
| ☐ Allow student time to themselves | |
| ☐ No PE/recess/activity | |
| Maintenance symptoms (such as mental fatigue, drowsiness, sleepy in class, sleeping too much at home, unable to sleep at home, unable to go to sleep or stay asleep) | |
| ☐ Rest breaks at school | |
| ☐ Student can come to school later in the day | |
| ☐ Half day for student | |
| ☐ Allow student to leave early | |
| ☐ No PE/recess/activity | |

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