Pius X High School Athletic Concussion Information

Dear Parent/Guardian:

- Enclosed is the Pius X Student Athlete Concussion information packet.
- No activity can be started until your student athlete has been evaluated by Drew Erks, Athletic Trainer OR Approved by a Healthcare Provider/Concussion Specialist (MD, DO, APRN, PA).
- Your student will also be entered into our Return to Learn Protocol to help aid the academic side of Concussion recovery. Return to Learn Information will be provided from Pius X Personnel (Academic Coordinator, School Nurse, etc.)
- Athletes will be required to complete a gradual exercise return protocol to help aid in recovery.
- Athletes will be provided Concussion Rehab exercises to help aid in recovery.
- Per state law, parent consent to return to activity, as well as clearance by approved Healthcare Provider (MD, DO, APRN, PA, or ATC) is required.

****PER PIUS X SCHOOL POLICY: STUDENT ATHLETES ARE EXEMPT FROM HOMEWORK, TESTS, AND QUIZZES ON THE NEXT SCHOOL DAY FOLLOWING A DOCUMENTED HEAD INJURY****

Concussion Return to Athletics Steps:

- ***All must be completed prior to Resuming Full Competition***

1) Symptom Free
2) Removed from Return to Learn (RTL) Accommodations
3) Completed Return to Play (RTP) Gradual Exercise Progression (Page #6)
4) Returned to Baseline Neurocognitive Test level (SWAY)
5) Parent Consent Form Signed (Page #5)
6) Clearance from Healthcare Provider (MD, DO, PA, APRN, or ATC)
    a. Can be Signed form (Page #5) or Physician note/email

Please contact me with any questions or concerns you may have.

Drew Erks, MSEd, ATC
Athletic Trainer
Pius X High School
drew-erks@cdolinc.net

Concussion Home Instructions for Parents

Name: ______________________________ Date of Injury: ___________ Date of Exam: ___________

Recommendations provided by: Drew Erks, MSEd, ATC drew-erks@cdolinc.net

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Head Pressure	0	1	2	3	4	5	6
	Neck Pain	0	1	2	3	4	5	6
	Nausea or Vomiting	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Blurred or Double Vision	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
	Sensitivity to Noise	0	1	2	3	4	5	6
Thinking/ Cognitive	Feeling "in a fog"	0	1	2	3	4	5	6
	Feeling Slowed Down	0	1	2	3	4	5	6
	Mental Fatigue	0	1	2	3	4	5	6
	"Don't Feel Right"	0	1	2	3	4	5	6
	Confusion	0	1	2	3	4	5	6
	Difficulty Concentrating	0	1	2	3	4	5	6
	Difficulty Remembering	0	1	2	3	4	5	6
Sleep Issues	Trouble Falling Asleep	0	1	2	3	4	5	6
	Trouble Staying Asleep	0	1	2	3	4	5	6
	Drowsiness	0	1	2	3	4	5	6
Emotions	Feeling More Emotional	0	1	2	3	4	5	6
	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervous or Anxious	0	1	2	3	4	5	6

The following steps were taken for your Child by school Personnel:

- ☐ Removed from Participation
- ☐ Checked for Neck/Spinal Injury
- ☐ Assessed for Orientation, Memory, Concentration, Balance and Vision Issues
- ☐ Restricted from any further participation and exertional activities
- ☐ Informed that they need to be evaluated by their family physician (Must be MD, DO, PA, or APRN)

Please watch out for the following Signs and Symptoms listed below. **The following indicate the need to report immediately to the nearest Emergency Department for further medical care**. In an emergency, activate Emergency Medical Services by dialing 911:

1. ***Headaches that increase in intensity***
2. ***Repeated Vomiting***
3. ***Decreased or irregular pulse or respiration***
4. ***Unequal, dilated, or unreactive pupils***
5. ***Slurred Speech***
6. ***Seizure Activity***
7. ***Changes in level of consciousness, very drowsy, difficulty awakening, or losing consciousness***
8. ***Can't recognize people or places, or becomes increasingly confused***

If you have questions or concerns about the signs and symptoms observed, contact your family physician for instructions, or seek medical attention at the closest medical facility.

IT IS OK TO:

- Rest and Sleep as needed
- Take a break if symptoms increase
- Use Acetaminophen (Tylenol) for Headaches
- Eat Normally
- Stay Hydrated

THERE IS NO NEED TO:

- Check eyes with Flashlight
- Wake up every hour to check, unless directed by physician
- Test Reflexes
- Stay in Bed

OTHER:

- **NO** Exercise until approved by Healthcare Provider (PE included)
- **LIMIT** any activity that increases symptoms: video games, cell phone use, driving, work, etc.
- **DO NOT** take ibuprofen, aspirin, naproxen or other NSAIDS.

Return to Play (**Level and activities will be determined by Healthcare Provider**)

Return to Sport

This tool is a guideline for managing an individual's return to sport following a concussion and does not replace medical advice. Timelines and activities may vary by direction of a health care professional.

STAGE 1:	STAGE 2:	STAGE 3:	STAGE 4:	STAGE 5:	STAGE 6:
No sporting activity	**Light aerobic exercise**	**Sport-specific exercise**	**Non-contact drills**	**Full-contact practice**	**Back in the game**
Physical and cognitive rest until symptoms start to improve OR after resting for 2 days max.	Walking, swimming, stationary cycling. No resistance training. The pace of these activities should be at the point where you are still able to have a conversation.	Skating drills (ice hockey), running drills (soccer). No head-impact activities.	Progress to complex training drills (e.g. passing drills). May start resistance training.	Following medical clearance participate in normal training activities.	Normal game play
Recovery	Increase heart rate	Add movement	Exercise, coordination, cognitive load	Restore confidence; assess functional skills	
Symptoms improve or 2 days rest max?	**No new or worsening symptoms for 24 hours?**	**No new or worsening symptoms for 24 hours?**	**Symptom-free for 24 hours?**	**Symptom-free for 24 hours?**	**Note: Premature return to contact sports (full practice and game play) may cause a significant setback in recovery.**
Yes: Move to stage 2	**Yes:** Move to stage 3	**Yes:** Move to stage 4	**Yes:** Move to stage 5	**Yes:** Move to stage 6	
No: Continue resting	**No:** Return to stage 1	**No:** Return to stage 2	**No:** Return to stage 3	**No:** Return to stage 4	
Time & Date completed:	Time & Date completed:	Time & Date completed:	Time & Date completed:	Time & Date completed:	

If new or worsening symptoms are experienced at any stage, go back to the previous stage for at least 24 hours. You many need to move back a stage more than once during the recovery process.

Medical clearance required before moving to stage 5

Pius X High School Post-Concussion Symptom Checklist

Name: ___________________ Date of Injury: __________ Date of Exam: __________

	Symptoms	None	Mild		Moderate		Severe	
Physical	Headache	0	1	2	3	4	5	6
	Head Pressure	0	1	2	3	4	5	6
	Neck Pain	0	1	2	3	4	5	6
	Nausea or Vomiting	0	1	2	3	4	5	6
	Dizziness	0	1	2	3	4	5	6
	Blurred or Double Vision	0	1	2	3	4	5	6
	Balance Problems	0	1	2	3	4	5	6
	Sensitivity to Light	0	1	2	3	4	5	6
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Thinking/ Cognitive	Feeling "in a fog"	0	1	2	3	4	5	6
	Feeling Slowed Down	0	1	2	3	4	5	6
	Mental Fatigue	0	1	2	3	4	5	6
	"Don't Feel Right"	0	1	2	3	4	5	6
	Confusion	0	1	2	3	4	5	6
	Difficulty Concentrating	0	1	2	3	4	5	6
	Difficulty Remembering	0	1	2	3	4	5	6
Sleep Issues	Trouble Falling Asleep	0	1	2	3	4	5	6
	Trouble Staying Asleep	0	1	2	3	4	5	6
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Emotions	Feeling More Emotional	0	1	2	3	4	5	6
	Irritability	0	1	2	3	4	5	6
	Sadness	0	1	2	3	4	5	6
	Nervous or Anxious	0	1	2	3	4	5	6

Total Symptoms: ___/23 **Symptom Score: ___/138**

Do symptoms worsen with physical activity? Yes____ No_____ Not Applicable_____

Do symptoms worsen with thinking/cognitive activity? Yes_____ No_____ Not Applicable_____

Activity Level: Over the past two days, compared to what I would typically do, my level of activity has been ______________% of what it would normally be

Pius X High School Concussion Parental Consent Form

Name:___________________________________ **Date of Injury:___________________**

MOI:_________________________________ **Grade:___________**

I, _______________________________________ am the parent/guardian of the student listed above. My child was removed from participation due to suspected concussion or head injury. By signing this form, I agree with the following:

- ***My child has been evaluated by a health care professional designated by the State of Nebraska with experience in managing Concussions.***
- ***We have been informed of the possible risks of concussions, including the risks to my child in continuing to play and practice after sustaining a concussion.***
- ***I understand that my child must complete the Return to Play protocol at acceptable levels before being allowed to resume participation.***
- ***I give my written consent and permission for my child to return to play and practice.***
- ***I give my written consent to remove my child from the school Return to Learn Protocol.***

Parent/Guardian Signature:____Date:_______________

Pius X High School Concussion Medical Clearance

- ***I have cleared the student listed above to return to play without restrictions.***
- ***I have explained the risks of returning to sport to the parents/guardians of the student listed above.***
- ***The student listed above has completed a Multi-day Return to Play protocol.***
- ***I am a licensed Healthcare Provider in the State of Nebraska and am trained in the evaluation and management of concussions.***
- ***I am a licensed Healthcare provider approved by Nebraska LB260 to clear an athlete to return to competition after a concussion (MD, DO, PA, APRN, or ATC).***

Healthcare Provider Signature: _______________________________________Date:_______________

Concussion Return to Play Gradual Exercise Progression

- Can be started 24-48 hours post injury. Steps 1-7 can be completed before being symptom free.
- If Symptoms increase, do not move to next step.
- 1 step can be completed per day unless otherwise instructed

STAGE 1:

1. Walk for 15-20 minutes Date:________________

STAGE 2:

(Depending on symptoms, could include Pushups, Sit ups, etc.)

2. Bike for 5 minutes-5 minutes rest-Bike for 5 minutes Date:________________
3. Bike for 15-20 minutes Date:________________
4. Bike for 10 minutes. Jog 10 yards-walk 10 yards-10 x Date:________________
5. Bike for 10 minutes. Jog 5 minutes-5 minutes break-Jog for 5 minutes Date:________________
6. Jog for 15-20 minutes Date:________________

- ***MUST HAVE SYMPTOM SCORE <15 TO CONTINUE***

STAGE 3:

7. Sport Specific workout (RTP sheet) 30-45 minutes of agilities/conditioning.
    a. Can start weight lifting after this workout is completed. Date:________________

- ***MUST BE SYMPTOM FREE TO CONTINUE***

STAGE 4:

8. Non-Contact Practice Date:________________

- SWAY Testing Back to Baseline Date:________________

STAGE 5:

9. Full Contact Practice Date:________________
    a. 2 Full Contact practices for FB, WR, and Soccer

STAGE 6:

10. Resume Competition Date:________________