Moravia Central School Concussion Protocol-Student-Athlete Version

Dear Parent/Guardian:

Your son/daughter has suffered a potential head/brain injury.

___ This possible injury occurred while under Moravia staff supervision, so attached is the initial evaluation that was completed. PLEASE DO NOT LOSE THAT EVALUATION FORM.

___ This possible injury occurred while your child was not under Moravia staff supervision, but was reported to ustriggering this protocol.

___ This possible injury occurred while your child was under Moravia staff supervision, but was not reported at that time and your child is now reporting symptoms of a potential brain injury, triggering this protocol.

We have a protocol in place for these situations that must be followed in order for an athlete to return to action.

Step 1:

If your child was referred to the hospital from practice/game play, the physician should complete the evaluation on the next page and you should bring that, along with this entire packet and any other paperwork they give you, to the nurse.

-OR-

If your child presented symptoms of a concussion and was held out of practice/game play, but not sent to the hospital, you need to schedule an appointment with your family physician right away. The physician evaluating him/her should complete the evaluation on the next page and you should bring that, along with this entire packet, to the nurse. Be sure to bring the initial evaluation form for the physician to consider when evaluating the child. (If you do not have a family physician, you can ask the school nurse to arrange an evaluation with the School Physician or his designee)

-OR-

If the possible injury was reported after the fact, or occurred when not under Moravia staff supervision, and you had your child evaluated by a physician, bring any paperwork from that evaluation to the school nurse for further evaluation.

-OR-

If the possible injury was reported after the fact, or occurred when not under Moravia staff supervision, and your child was not yet evaluated by a physician you need to schedule an appointment with your family physician right away. The physician evaluating him/her should complete the evaluation on the next page and you should bring that, along with this entire packet, to the nurse. Be sure to bring the initial evaluation form for the physician to consider when evaluating the child. (If you do not have a family physician, you can ask the school nurse to arrange an evaluation with the School Physician or his designee).

-OR-

If your child did not present concussion systems and was allowed to return to practice/game play that day, do not assume there was definitely not a concussion. Continue to monitor your child's health, behavior, etc. for the next 24 hours and call your family physician or take your son/daughter to the emergency room should any of the following occur:

- Headache continues or worsens
- Nausea or vomiting
- Impaired memory
- Unusual drowsiness or difficult to arouse.
- Changes in level of consciousness, alertness or personality.
- Blood or other fluids draining from the ears or nose.
- Convulsions or seizures.
- Dizziness, trouble with coordination or balance.
- Disturbances in vision, hearing or speech.
- 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

Step 2:

If the evaluating physician diagnoses a concussion, the nurse will assign a return to play protocol that will require a final approval by the School Physician (or his designee) in order for your child to return to practice/game play fully.

If no concussion is diagnosed and the evaluating physician signs off as such without any further restrictions, your child can return to practice/game play the next day, provided this packet is turned in to the nurse in its entirety.

Moravia Central School Concussion Protocol-Student-Athlete Version

Student Name: ______________________________ Age: _______ Sport: ___________________________

Date of incident: ____/____/____ Approximate time of incident: ______:_______ am / pm

Location of incident:

Brief description of incident:

Conclusion of the Initial Incident

Check one of the following and complete each of the assigned steps:

Option A:

__ Student was evaluated via the above checklist at the time the incident was noted/reported, **AND** 15 minutes following that **AND** 30 minutes after the initial evaluation, and was found to have **NONE** of the above symptoms

-Circle one: He/She was returned to practice/game play ~OR~ He/She was held out further

-Parents/Guardians were notified about incident and were given the note on the next page

(Date/time: _________________ How: In person / Via phone)

-This sheet is to be returned to the nurse

Option B:

__ Student was evaluated via the above checklist and found to have one or more symptoms present

-He/She was kept out of the remainder of the game/practice

-Check one of the following:

__ He/She was transported to the hospital via ambulance

__ He/She was released to parent(s)/guardian(s)

__ He/She was released, WITH PARENTAL CONSTENT (Consent given to staff member in person or via phone)

-This packet is to go with the student in whatever manner he/she is released...remind them not to lose it. If released to self or parents, have the parents go on to the next page. If the student is sent to the hospital, have them complete page 4 when they evaluate the child.

-A separate incident report must be filled out by the coach and submitted to the nurse within 24 hours for follow up

Option C:

__ The initial incident, while occurring under Moravia staff supervision, was not noticed by staff and not reported by the student, but symptoms presented later after the student left Moravia staff care, leading to this protocol being initiated.

Option D:

__ The initial incident occurred while the student was not under Moravia staff supervision. Concussion symptoms presented and were reported to Moravia staff, leading to this protocol being initiated.

Staff Signature:____ Title:___________________________

Head Injury Evaluation

Name of Student: ______________________ **DOB:** __________________

Injury Date: __________________________ **Sport:** _________________

Physician Evaluation

Date of First Evaluation:______________ Time of Evaluation: ________________

Date of Second Evaluation: ____________ Time of Evaluation: ________________

Symptoms Observed:	First Doctor Visit	Second Doctor Visit
Dizziness	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
Sensitivity to Light	Yes No	Yes No
Sensitivity to Noise	Yes No	Yes No
Anterograde Amnesia (After impact)	Yes No	N/A N/A
Retrograde Amnesia (Backwards in time from impact)	Yes No	N/A N/A

First Doctor Visit:

Did the athlete sustain a concussion? (Yes or No) (One or the other must be circled)
** Post-dated releases will not be accepted. The athlete must be seen and released on the same day.

Is this the student's first concussion? (Yes or No)
Please note that if there is a history of previous concussion, then a referral for professional Management by a specialist or concussion clinic should be strongly considered.

Additional Findings/Comments______________________________________
And/or Diagnostic Tests:
Recommendations/Limitations: ______________________________________

MD Signature: ___________________________ Date:____________________

MD Print or stamp name: _____________________ Phone number:______________

Second Doctor Visit:

*** Athlete must be completely symptom free before beginning six-step return to play.
If an athlete still has symptoms more than seven days after injury, referral to a concussion specialist/clinic should be strongly considered.

Please check one of the following:

____ Athlete is asymptomatic and is ready to begin the six-step return to play.

____ Athlete is still symptomatic more than seven days after injury.

Signature: ______________________ Date:____________________
Print or stamp name: ______________ Phone number: _______________