Allen ISD Athletic Department

Allen ISD Middle School Concussion Documentation Procedures

Allen Independent School District
Allen Athletic Facility * 301 Rivercrest Allen, TX 75002* (972) 727-0437 *Fax (972) 727-7103

Allen ISD Middle School Injury Report Form – Concussion Management

To be completed by supervising coach who witnessed the injury or who the athlete reported the injury to. Once complete this form must be sent to the Allen ISD Athletic Trainer responsible for the middles school within 24 hours of injury.

Athlete Last Name: ___________________________ Athlete First Name: __________________________

Campus: ____________ Grade: _____ Student ID #:___________ Sport: ______________

Date of Injury: ___________ Time: ___________ Site: ____________ Game or Practice (Circle One)

Describe how injury occurred:____
____
____

Initial Signs/Symptoms:

Loss of Consciousness: Yes or No Appears Dazed: Yes or No Forgets events of Game: Yes or No

Headache: Yes or No Nausea/Vomiting: Yes or No Balance Problems: Yes or No Lightheaded: Yes or No

Dizziness: Yes or No Sensitive to light or noise: (circle one or both) feeling tired or sluggish: Yes or No

Initial Treatment: **ATHLETE SHOULD BE REMOVED FROM ACTIVITY IMMEDIATLEY.**

____

Parent Contact Information: ____

Was athlete taken to Emergency Room? Yes or No

Was athlete diagnosed with a concussion or closed head injury by physician? Yes or No

If no, athlete will follow written Physician orders and will be released to play as per Physician orders

If yes, athlete must follow Physician orders and be re-evaluated by the athletes treating physician or Allen ISD team physician for final clearance to begin the return-to-play protocol. **The Allen ISD Return to Play Release Form must be completed by the treating physician.**

Coach Name (Print): _______________________________ Contact Number: _____________________________

Coach Signature: ___________________________________ Date: __________

Date and Time Athlete seen in HS Training Room: _____/_____/_____ _____________am/pm

Athletic Trainer: ____

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ALLEN ISD Home Instructions for Concussion

Your son/daughter has sustained a head injury while participating in an athletic practice/event. In some instances, the signs of a concussion do not become obvious until several hours or even days after the injury. Please be especially observant for the following signs and symptoms. (For further information regarding Concussions go to https://www.cdc.gov/headsup/youthsports/index.html)

1. Headache (especially one that increases in intensity*)
2. Nausea and vomiting*
3. Difference in pupil size from right to left eye, dilated pupils*
4. Mental confusion/behavior changes
5. Dizziness
6. Memory loss
7. Ringing in the ears
8. Changes in gait or balance
9. Blurry or double vision*
10. Slurred speech*
11. Noticeable changes in the level of consciousness (difficulty awakening, or losing consciousness suddenly)*
12. Seizure activity*
13. Decreased or irregular pulse OR respiration*

*** Seek medical attention at the nearest emergency department or call 911.**

The best guideline is to note symptoms that worsen, and behaviors that seem to represent a change in your son/daughter. If you have any question or concern at all about the symptoms you are observing, contact your family physician for instructions, or seek medical attention at the closest emergency department. Otherwise, you can follow the instructions outlined below.

It is OK to:
- **Use acetaminophen (Tylenol) for headaches**
- **Use ice pack on head & neck as needed for comfort**
- **Eat a light diet**
- **Go to sleep**
- **Rest (no strenuous activity or sports)**

There is NO need to:
- **Check eyes with a flashlight**
- **Wake up every hour**
- **Test reflexes**
- **Stay in bed**

Do NOT:
- **Drink alcohol**
- **Drive while symptomatic**
- **Exercise or lift weights**
- **Take ibuprofen, aspirin, naproxen or other non-steroidal anti-inflammatory medications**
- **Watch TV, Video Games, Computer**
- **Listen to IPod or Use Phone**

Return to Play Procedure:

- **If a concussion is suspected by a coach, athletic Trainer, nurse, physician, or parent/guardian the athlete is to be removed from play immediately with no return to activity until seen by a physician (MD/DO).**
- **Parent/Guardian should be instructed to contact an Allen ISD athletic trainer after the injury to set up a physician appointment and/or review any documentation from a physician, if athlete has been evaluated.**
- **Coach must make contact with Mike Harrison, Mary Miller, Chay Nersesian, or Chris Brock, cell phone or email notifying them of the injury and complete the attached injury report form.**
- **Athlete must be cleared by a Physician (MD/DO) to return to any physical activities**
  - **Athlete may be cleared by a physician to return to athletic play; however, the athlete must complete the 5 step return to play progression protocol per the Allen ISD Policy before being allowed to full participation.**

Follow up with an ImPACT Certified Physician:

Dr. Sterling –469-800-7540
Dallas
www.bswsportsconcussion.com

Dr. Kester -214-383-9356
Allen
www.allenorthopedicsandsportsmedicine.com

Dr. Shane Miller – 469-515-7100
www.tsrhc.org/sports

Children's Health Andrew's Institute for Children – 469-303-3000
www.childrens.com/andrews

Allen ISD Athletic Department

Steps for Middle School Athlete Concussion Treatment and Return to Play

1. Remove Athlete from Play or Participation immediately with no return to activity

2. Seek Medical Attention:

   a. E.R. – May only evaluate and diagnose. May not clear the athlete to Return to Play per State Law
   b. ImPACT Credential Physicians
      i. Dr. Sterling – 214-265-3200
      ii. Dr. Kester - 214-383-9356
      iii. Scottish Rite Children's Plano – 469-515-7100
      iv. Children's Health Andrews Institute – 469-303-3000
      v. Family Physician, Care Now, Etc. – Note if the athlete see's their own physician, they will be out of athletic participation for a minimum of 3 weeks, is symptom free, have Physician clearance, and must complete the 5 step return to play progression before being released to play.

3. Contact Allen ISD Athletic Trainer:

   a. Curtis MS – Chay Nersesian – 214-250-6166
   b. Ereckson MS – Mary Miller – 214-418-7204
   c. Ford MS – Mike Harrison – 214-448-5351

4. Return to Play Procedure

   a. Contact Allen Sports and Spine Care (214-509-0029) to schedule the 5 step Physical Progression. The first 3 days will be done with Allen Sports & Spine Care, Day 4 & 5 will be done with their respective sport, under their coach's supervision, with increasing sport specific activity each day.
   b. If the Athlete is suspected of having a concussion but is not diagnosed for a concussion by the Healthcare provider, then the athlete must complete the first 3 steps of the Return to Play progression.
   c. After completion of the 5 Step Progression, **Please contact/see the Allen ISD Athletic Trainer for your respective school for the Return to Play Release Form**. The athlete will not be released to play until the final form is signed by the Physician, Parent and Athletic Trainer per state law.

Note: Athletes sustaining a head injury outside of school activity will follow the same procedure as stated above.

Return to Play Progression Protocol

Athlete Name: ______________________________ ID#: ______________ Grade: ________

Sport: __________________ School/Coach: _____________________ Date of Injury: ____/____/____

Date of Physician Evaluation: ____/____/____ Physician: ___________________________

Step 1: Supervised, light aerobic activity (5 min. Walk/light jog, 2 light 40yd sprints, Balance training) No weight training

____________________________	____________________________	____/____/____
Printed Name of Student	**Student Signature**	**Date**
____________________________	____________________________	____/____/____
Printed Name of Athletic Trainer	**Signature of Athletic Trainer**	**Date**

Notes/Comments: Post Work out ask: Do you have a Headache? Y or N Do you feel Dizzy/Lightheaded? Y or N Do you feel Nauseated? Y or N

Step 2: Supervised, moderate aerobic activity (10 min. jog, 4 40yd sprints, Balance training) light strength training

____________________________	____________________________	____/____/____
Printed Name of Student	**Student Signature**	**Date**
____________________________	____________________________	____/____/____
Printed Name of Athletic Trainer	**Signature of Athletic Trainer**	**Date**

Notes/Comments: Post Work out ask: Do you have a Headache? Y or N Do you feel Dizzy/Lightheaded? Y or N Do you feel Nauseated? Y or N

Step 3: Supervised, mod-aggressive aerobic activity (15 min. jog, 6 40yd sprints, Balance Training) Full Strength Training

____________________________	____________________________	____/____/____
Printed Name of Student	**Student Signature**	**Date**
____________________________	____________________________	____/____/____
Printed Name of Athletic Trainer	**Signature of Athletic Trainer**	**Date**

Notes/Comments: Post Work out ask: Do you have a Headache? Y or N Do you feel Dizzy/Lightheaded? Y or N Do you feel Nauseated? Y or N

Step 4: Team Non – Contact drills appropriate to sport – Continue with Conditioning and Strength Training

____________________________	____________________________	____/____/____
Printed Name of Student	**Student Signature**	**Date**
____________________________	____________________________	____/____/____
Printed Name of Athletic Trainer/Coach	**Signature of Athletic Trainer/Coach**	**Date**

Notes/Comments: Post Work out ask: Do you have a Headache? Y or N Do you feel Dizzy/Lightheaded? Y or N Do you feel Nauseated? Y or N

Step 5: Team Full Contact Drills appropriate to sport – Full exertion for sport

____________________________	____________________________	____/____/____
Printed Name of Student	**Student Signature**	**Date**
____________________________	____________________________	____/____/____
Printed Name of Athletic Trainer/Coach	**Signature of Athletic Trainer/Coach**	**Date**

Notes/Comments: Post Work out ask: Do you have a Headache? Y or N Do you feel Dizzy/Lightheaded? Y or N Do you feel Nauseated? Y or N

Step 6: **All aspects of the above Return to Play protocol have been meet. Athlete may return to full participation once the Return to Play form is signed and completed by all parties (Physician, Athletic Trainer and Parent Signature) and on file with the Allen ISD Athletic Trainer.**

- ***Coaches may only administer steps 4 and 5 and are not allowed to administer Steps 1-3***

Mike Harrison, ATC, LAT * Mary Miller, ATC, LAT * Chay Nersesian, ATC, LAT *Chris Brock, LAT
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UIL/ALLEN ISD Concussion Management Protocol and Return to Play Release Form

This form must be completed and submitted to the athletic trainer or other person (who is not a coach) responsible for compliance with Return to Play protocol established by the school district Concussion Oversight Team, as determined by the superintendent or their designee (see Section 38.157 © of The Texas Education Code).

Name: ______________________________ School:______________________ Date: ________________

Sex: Male Female (Circle) Age:__________ DOB:________________ Date of Injury:________________

Sport:_______________________ Position:______________

Complaint:_________________________________ New Injury Re-Injury Follow-up (Circle)

Diagnosis:____

Patient is allowed to begin the Stepwise Return-to-Play Progression program of the Allen ISD concussion protocol. He or she may return to sports after successfully completing the protocol requirements.

Physician Signature: ____ Date:________________

____________________________ ____________________________________ ____________________

Printed Physician Name Physician Address Phone

Designated School District Official Verifies:

- ☐ The student has been evaluated and by a treating physician selected by the student, their parent or other person with legal authority to make medical decisions for the student.
- ☐ The student has completed the Return-to-Play protocol established by the Allen ISD Concussion Oversight Team.
- ☐ The school has received a written statement from the treating physician indicating, that in the physician's professional judgment, it is safe for the student to return to play.

Athlete Trainer Signature/ (Print):_______________________/______________________ Date:________________

Parent/Guardian with legal authority to make medical decisions for the student signs and certifies he/she:

- ☐ Has been informed concerning and consents to the student participating in returning to play in accordance with the return to play protocol established by the Allen ISD Concussion Oversight Team.
- ☐ Understands the risks associated with the student returning to play and will comply with any ongoing requirements in the return to play protocol.
- ☐ Consents to the disclosure to appropriate persons, consistent with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), of the treating physician's written statement under Subdivision (3) and, if any, the return to play recommendations of the treating physician.
- ☐ Understands the immunity provisions under Section 38.159 of the Texas Education Code.

What are the risks for playing with a concussion or returning to play to soon?

Research indicates that student-athletes who return to athletic participation before completely recovering from an initial concussion injury have an increased risk of sustaining a second concussion. This re-injury often results from a seemingly insignificant blow or contact and usually results in a longer recovery period. These athletes are also at risk for "Second Impact Syndrome". Second Impact Syndrome results in rapid brain swelling, brain damage and in some case death.

By signing this form I understand the dangers related of returning to soon after a sport-related concussion. Furthermore, I certify that the above athlete has successfully completed the Allen ISD Concussion return to play protocol and has been released by a licensed Physician with ImPACT credentials to return to play. I understand that upon my signature and return of this release form to the Allen ISD athletic trainer the above athlete will be allowed to return to full participation in practice and competition.

If you have any questions please do not hesitate to call an Allen ISD Athletic Trainer.

Parent/Legal Guardian:________________________________
(Printed Name)

Parent/Legal Guardian:________________________________ Date: ______________________________
(Signature)