HEAD INJURY NOTIFICATION

Athlete: ________________________ Date of Injury: ____________ Sport: _________________

Your daughter sustained a head injury (suspected concussion) while participating in athletics. The following mechanism and symptoms were observed: ____
____.

Your daughter should be monitored by a responsible adult and should not be left alone over the next 12-24 hours. Please know that symptoms may subside or worsen in the coming hours and days, but new symptoms may present as well. **Please call 9-1-1 and go to the nearest emergency department if you observe**:

1. Headache especially increasing intensity
2. Nausea and vomiting
3. Blurry or double vision
4. Memory or recognition difficulties
5. Unequal pupil size or unusual dilation
6. Slurred speech
7. Changes in gait or balance
8. Weakness/tingling in arms or legs
9. Difficulty awakening, looks very drowsy, or loses consciousness suddenly
10. Seizures, convulsions, or tremors
11. Decreased or irregular pulse or respiration
12. Loss of bowel/bladder control
13. Mental confusion/behavioral changes
14. Drainage of blood/fluid from the ears or nose

Ibuprofen, aspirin, narcotics, and other medications are not recommended unless specified by your daughter's physician. It is okay to allow your daughter to sleep, drink plenty of fluids, and eat light, healthy meals. Your daughter should avoid physical activity and driving until cleared by a physician; and limit mental activities and screen time (ex. watching TV, cellphones, computer/tablet screens) that exacerbate her symptoms. Check your daughter for normal breathing while sleeping every few hours, but do not wake her unless you are concerned. If you have any questions or concerns regarding symptoms you are observing, contact your family physician for instructions or seek immediate medical attention.

Per California law AB 2127, your daughter must be evaluated by a physician (MD or DO) trained in the diagnosis and management of concussions, and receive written clearance before she will be allowed to return to athletic participation. When seeing your daughter's physician, please bring this packet with you and have the "REQUIRED" forms completed and returned to Presentation High. Once cleared and symptom-free, your daughter will go through a gradual return-to-play protocol of no less than seven days from the time she is diagnosed. For more information regarding this law, please see the CIF's Concussion Return to Play Protocol page in this packet. Your daughter must check in daily with the athletic trainer before she may progress to the next step in the return-to-play protocol.

Heather Terbeek, MA, ATC, CES, ITAT
Head Athletic Trainer
Presentation High School
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Physician Head Injury Report (Required)

Patient Name: ________________________________ Date of Injury: ______________

Injury Status

☐ Has been diagnosed by a physician (MD/DO) with a concussion and is under medical care
She has a medical follow-up date on (date if applicable): ______________

☐ Was evaluated and did not sustain a concussion injury. There are no limitations on school or physical activity.

Academic Activity Status *(Please indicate all, if any, that apply)*

☐ This student is not to return to school.

☐ This student may begin a return to school with the school accommodations as specified on the ***Physician Recommended Post-Concussion School Accommodations*** form.

☐ This student is no longer experiencing any signs/symptoms of a concussion and may return to full academic participation.

Comments: ____

Physical Activity Status *(Please indicate all, if any, that apply)*

☐ This student is currently not to participate in physical activity of any kind.

☐ This student is not to participate in physical activity except for untimed, voluntary walking.

☐ This student may begin a monitored, graduated return to play progression following the ***CIF Concussion RTP Protocol form*** (see attached).

☐ This student is cleared for full, unrestricted athletic participation after completing the ***CIF Concussion RTP Protocol***.

Comments: ____

Physician (MD/DO) Signature: __________________________________ **Exam Date:** ______________

Physician Stamp & Contact Information:

Parent/Guardian Signature: _____________________________________ **Date**: _________________

Revised & Adapted from CIF Recommended Guidelines 4/16

CIF Concussion Return to Play (RTP) Protocol

CA STATE LAW AB 2127 STATES THAT RETURN TO PLAY (I.E., COMPETITION) CANNOT BE SOONER THAN 7 DAYS AFTER EVALUATION BY A PHYSICIAN (MD/DO) WHO HAS MADE THE DIAGNOSIS OF CONCUSSION, AND ONLY AFTER COMPLETING A GRADUATED RETURN TO PLAY PROTOCOL.

Instructions:

- This is an example of a *graduated return to play protocol* that MUST be completed before you can return to FULL COMPETITION.
  - A certified athletic trainer (AT), physician, or identified concussion monitor (e.g., athletic director, coach), must initial each stage after you successfully pass it.
  - You should be back to normal academic activities before beginning Stage II, unless otherwise instructed by your physician.
- After Stage I, you cannot progress more than one stage per day (or longer if instructed by your physician).
- If symptoms return at any stage in the progression, IMMEDIATELY STOP any physical activity and follow up with your school's AT, other identified concussion monitor, or your physician. In general, if you are symptom-free the next day, return to the previous stage where symptoms had not occurred.
- Seek further medical attention if you cannot pass a stage after 3 attempts due to concussion symptoms, or if you feel uncomfortable at anytime during the progression.

<table>
<tr><td colspan="5">You must have written physician (MD/DO) clearance to begin and progress through the following Stages as outlined below, or as otherwise directed by your physician. Minimum of 6 days to pass Stages I and II.</td></tr>
<tr><th>Date & Initials</th><th>Stage</th><th>Activity</th><th>Exercise Example</th><th>Objective of the Stage</th></tr>
<tr><td></td><td>I</td><td>No physical activity for at least 2 full symptom-free days</td><td>• No activities requiring exertion (weight lifting, jogging, P.E. classes)</td><td>• Recovery and elimination of symptoms</td></tr>
<tr><td></td><td>II-A</td><td>Light aerobic activity</td><td>• 10-15 minutes (min) of walking or stationary biking.
• Must be performed under direct supervision by designated individual</td><td>• Increase heart rate to no more than 50% of perceived maximum (max) exertion (e.g.,< 100 beats per min)
• Monitor for symptom return</td></tr>
<tr><td></td><td>II-B</td><td>Moderate aerobic activity
(Light resistance training)</td><td>• 20-30 min jogging or stationary biking
• Body weight exercises (squats, planks, push-ups), max 1 set of 10, no more than 10 min total</td><td>• Increase heart rate to 50-75% max exertion (e.g.,100-150 bpm)
• Monitor for symptom return</td></tr>
<tr><td></td><td>II-C</td><td>Strenuous aerobic activity
(Moderate resistance training)</td><td>• 30-45 min running or stationary biking
• Weight lifting ≤ 50% of max weight</td><td>• Increase heart rate to > 75% max exertion
• Monitor for symptom return</td></tr>
<tr><td></td><td>II-D</td><td>Non-contact training with sport-specific drills
(No restrictions for weightlifting)</td><td>• Non-contact drills, sport-specific activities (cutting, jumping, sprinting)
• No contact with people, padding or the floor/mat</td><td>• Add total body movement
• Monitor for symptom return</td></tr>
<tr><td colspan="5">Prior to beginning Stage III, please make sure that written physician (MD/DO) clearance for return to play, after successful completion of Stages I and II, has been given to your school's concussion monitor.</td></tr>
<tr><td rowspan="2"></td><td rowspan="2">III</td><td>Limited contact practice</td><td>• Controlled contact drills allowed (no scrimmaging)</td><td rowspan="2">• Increase acceleration, deceleration and rotational forces
• Restore confidence, assess readiness for return to play
• Monitor for symptom return</td></tr>
<tr><td>Full contact practice
Full unrestricted practice</td><td>• Return to normal training, with contact
• Return to normal unrestricted training</td></tr>
<tr><td colspan="5">MANDATORY: You must complete at least ONE contact practice before return to competition, or if non-contact sport, ONE unrestricted practice
(If contact sport, highly recommend that Stage III be divided into 2 contact practice days as outlined above)</td></tr>
<tr><td></td><td>IV</td><td>Return to play (competition)</td><td>• Normal game play (competitive event)</td><td>• Return to full sports activity without restrictions</td></tr>
</table>

Athlete's Name: ____

Date of Concussion Diagnosis: ________________

Physician Recommended Post-Concussion School Accommodations

Patient Name: ______________________________ Parent Name: ___________________________

I give permission for my physician to share the following information with my child's school and for communication to occur between the school and my physician for changes to this plan.

Parent Signature: _____________________________ Date: _______________

This patient has been diagnosed with a concussion and is currently our care. The following are suggestions for academic adjustments to be individualized for the student as deemed appropriate in the school setting. Adjustments can be modified as the student's symptoms improve/worsen. Please see the CIF Return to Learn Protocol for more information at cifstate.org.

Area	Requested Modifications	Comments or Clarifications
Attendance	☐ No school ☐ Partial school day as tolerated by student ☐ Full school day as tolerated by student ☐ Water bottle/snack in class every 3-4 hours	
Breaks	☐ Mandatory Breaks: _____________________________ ☐ Allow breaks during the day as deemed necessary by student or teachers/school personnel	
Visual Stimulus	☐ Pre-printed notes or note taker for class material ☐ Limited computer, TV screen, bright screen use ☐ Allow handwritten assignments as opposed to electronically typed ☐ Allow student to wear sunglasses/hat in school; seat her away from windows/bright lights ☐ Reduce brightness on monitors/screens ☐ Change classroom seating to front of room as necessary	
Auditory Stimulus	☐ Avoid loud places (i.e. music, band, choir, gym, and cafeteria) ☐ Allow student to wear earplugs as needed	
School Work	☐ Will attempt homework, but will rest if symptoms occur. Course load will be adjusted as needed with assistance from the learning specialist ☐ Extended deadlines for assignments, projects, and quizzes (specify)	
Testing	☐ Delayed testing dates until: ___________ ☐ No more than _____ test(s) per day **Sections of tests may be given as tolerated by student*	
Physical Activity	☐ No physical exertion/athletics/dance/PE class ☐ Walking in PE/dance class only ☐ May begin return to play following the CIF Return to Play (RTP) protocol (see page in packet)	

The patient will be reevaluated for revision of these recommendations on ____________________.

Physician Name & Contact Information: ____

Physician Signature: ____________________________________ Date: _______________

CIF GRADED CONCUSSION SYMPTOM CHECKLIST

Today's Date: ______________ **Time:** ______________ **Hours of Sleep:** ______________ **Date of Diagnosis:** ______________

☐ **Baseline Score**
☐ **Post Concussion Score**

- **Grade the 22 symptoms with a score of 0 through 6.**
  - *Note that these symptoms may not all be related to a concussion.*
- **You can fill this out at the beginning of the season as a baseline** *(after a good night's sleep).*
- **If you suffer a suspected concussion, use this checklist to record your symptoms daily.**
  - *Be consistent and try to grade either at the beginning or end of each day.*
- **There is no scale to compare your total score to; this checklist helps you follow your symptoms on a day-to-day basis.**
  - *If your total scores are not decreasing, see your physician right away.*
- **Show your baseline (if available) and daily checklists to your physician.**

	None	Mild		Moderate		Severe	
Headache	0	1	2	3	4	5	6
"Pressure in head"	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 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
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
"Don't feel right"	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
Fatigue or low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6
More emotional than usual	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 SUM OF EACH COLUMN	0						
TOTAL SYMPTOM SCORE *(Sum of all column totals)*							

NAME ______________________________ **HIGH SCHOOL** ______________________________

D.O.B. ______________ **SPORT** ______________ **PHYSICIAN (MD/DO)** ______________________________