EASTERN CHRISTIAN

WRITTEN CLEARANCE/RETURN TO PLAY FORM FOR CONCUSSED ATHELTES

Athlete name: _____DOB (Age): _____ (_____)
High School: ☐ Middle School: ☐ Sport: _____

INJURY HISTORY

Date of injury: _____ Time injury occurred: _____
Time removed from play: _____ Period/quarter/half removed from play: _____
Who removed athlete from play: ☐ Coach ☐ Official ☐ Other
Sideline evaluation performed by: _____
Brief description of symptoms noted during sideline evaluation: _____
_____
Time returned to play: _____ Period/quarter/half returned to play: _____

NJSIAA CONCUSSION MANAGEMENT GUIDLEINES

A student-athlete who participates in an interscholastic sports program and who sustains or is suspected of sustaining a concussion or other head injury while engaged in a sports competition or practice shall be immediately removed from activity. A student-athlete who is removed from competition or practice shall not participate in further sports activity until he/she is evaluated by a physician who is trained in the evaluation and management of concussions, **and receives written clearance from a physician trained in the evaluation and management of concussions to return to activity.**

PHYSICIAN'S EVALUATION FINDINGS

Date of Evaluation: ____/____/_____ Time of evaluation: _____

CT Scan: ☐ Not needed ☐ Negative ☐ Positive

DIAGNOSIS OF CONCUSSION (initial one):

____ ABSENT:
On this day, the _____ of _____, 20_____, I hereby authorize the above named student to return to play and participate in competition without restrictions.

____ PRESENT:
The above named student has sustained a concussion and should NOT return to participation in athletics until all NJSIAA and School District Return-To-Play criteria have been met.

- **IF PRESENT PAGE 2 AND 3 MUST BE COMPLETED and**
- **Must complete Graduated Return to Practice and Competition Protocol Form**

By signing below, I hereby certify that I have received training in the evaluation and management of concussions. (N.J.S.A. 18A:40-41,4)

PHYSICIAN SIGNATURE_____ ☐ M.D. ☐ D.O. (check one)

PHYSICIAN NAME PRINTED_____ DATE:_____

OFFICE ADDRESS _____

_____

TELEPHONE No. _____

Acute Concussion Evaluation (Ace) Care Plan

NAME:_____ DATE:_____

You have been diagnosed with a concussion (also known as a mild traumatic brain injury). This personal plan is based on your symptoms and is designed to help speed your recovery. Your careful attention to it can also prevent further injury. You should not participate in any high risk activities (e.g., sports, physical education (PE), riding a bike, etc.) if you still have any of the symptoms below. It is important to limit activities that require a lot of thinking or concentration (homework, job-related activities), as this can also make your symptoms worse. If you no longer have any symptoms and believe that your concentration and thinking are back to normal, you can slowly and carefully return to your daily activities. Children and teenagers will need help from their parents, teachers, coaches, or athletic trainers to help monitor their recovery and return to activities.

Today the following symptoms are present (circle or check) OR _____No reported symptoms

Physical		Thinking	Emotional	Sleep
Headaches	Sensitivity to light	Feeling mentally foggy	Irritability	Drowsiness
Nausea	Sensitivity to noise	Problems concentrating	Sadness	Sleeping more than usual
Fatigue	Numbness/Tingling	Problems remembering	Feeling more emotional	Sleeping less than usual
Visual Problems	Vomiting	Feeling more slowed down	Nervousness	Trouble falling asleep
Balance Problems	Dizziness			

DANGER SIGNS: Call your doctor or go to your emergency department if you suddenly experience any of the following			
Headaches that worsen	Look very drowsy, can't be awakened	Increasing confusion	Unusual behavior change
Repeated vomiting	Can't recognize people or places	Slurred speech	Increasing irritability
Seizures	Weakness or numbness in arms and legs	Neck pain	Loss of consciousness

RETURNING TO DAILY ACTIVITY

1. Get lots of rest. Be sure to get enough sleep at night- no late nights. Keep the same bedtime weekdays and weekends.
2. Take daytime naps or rest breaks when you feel tired or fatigued.
3. **Limit physical activity as well as activities that require a lot of thinking or concentration. These activities can make symptoms worse.**
    - Physical activity includes PE, sports practices, weight-training, running, exercising, heavy lifting, etc.
    - Thinking and concentration activities (e.g., homework, classwork load, job-related activity).
4. Drink lots of fluids and eat carbohydrates or protein to main appropriate blood sugar levels.
5. **As symptoms decrease, you may begin to gradually return to your daily activities. If symptoms worsen or return, lessen your activities, then try again to increase your activities gradually.**
6. During recovery, it is normal to feel frustrated and sad when you do not feel right and you can't be as active as usual.
7. Repeated evaluation of your symptoms is recommended to help guide recovery.

RETURNING TO SCHOOL

1. If you (or your child) are still having symptoms of concussion you may need extra help to perform school-related activities. As your (or your child's) symptoms decrease during recovery, the extra help or supports can be removed.
2. Inform the teacher(s), school nurse, school psychologist or counselor, and administrator(s) about your (or your child's) Injury and symptoms. School personnel should be instructed to watch for:
    - Increased problems paying attention or concentrating.
    - Increased problems remembering or learning new information.
    - Longer time needed to complete tasks or assignments.
    - Greater irritability, less able to cope with stress.
    - Symptoms worsen (e.g., headache, tiredness) when doing schoolwork.

~Continued on back page~

RETURNING TO SCHOOL (CONTINUED)

Until you (or your child) have fully recovered, the following supports are recommended: *(check all that apply)*

___No return to school. Return on (date)_____
___Return to school with following supports. Review on (date)_____
___Shortened day. Recommend___ hours per day until (date)_____
___Shortened classes (i.e., rest breaks during classes). Maximum class length: _____ minutes.
___Allow extra time to complete coursework/assignments and tests.
___Lessen homework load by _____%. Maximum length of nightly homework: _____ minutes.
___No significant classroom or standardized testing at this time.
___Check for the return of symptoms (use symptom table on front page of this form) when doing activities that require a lot of attention or concentration.
___Take rest breaks during the day as needed.

RETURNING TO SPORTS

1. **You should NEVER return to play if you still have ANY symptoms** – (Be sure that you do not have any symptoms at rest and while doing any physical activity and/or activities that require a lot of thinking or concentration.)
2. Be sure that the PE teacher, coach, and/or athletic trainer are aware of your injury and symptoms.
3. It is normal to feel frustrated, sad and even angry because you cannot return to sports right away. With any injury, a full recovery will reduce the chances of getting hurt again. It is better to miss one or two games than the whole season.

The following are recommended at the present time:

___ Return to PE class
___ Do not return to PE class at this time
___ Do not return to sports practices/games at this time
___ **Gradual** return to sports practices under the supervision of an appropriate health care provider.

- Return to play should occur in gradual steps beginning with aerobic exercise only to increase your heart rate (e.g., stationary cycle); moving to increasing your heart rate with movement (e.g., running); then adding controlled contact if appropriate; and finally return to sports competition.
- Pay careful attention to your symptoms and your thinking and concentration skills at each stage of activity. Move to the next level of activity only if you do not experience any symptoms at the each level. If your symptoms return, stop these activities and let your health care professional know. Once you have not experienced symptoms for a minimum of 24 hours and you receive permission from your health care professional, you should start again at the previous step of the return to play plan.

This referral plan is based on today's evaluation: DATE:_____

___ Return to this office. Date/Time _____
___ Refer to: Neurosurgery____ Neurology____ Sports Medicine____ Physiatrist____ Psychiatrist____ Other____
___ Refer for neuropsychological testing
___ Other

ACE Care Plan Completed by:_____ MD RN NP PhD ATC