National Federation Sport Concussion Rule

The following wording appears in all the National Federation Sport Rules Codes:

> "Any player who exhibits signs, symptoms or behaviors consistent with a concussion (such as loss of consciousness, headache, dizziness, confusion, or balance problems) shall be immediately removed from the contest and shall not return to play until cleared by an appropriate health-care professional."

MPSSAA Interpretation

To provide guidance for coaches, players and parents regarding the application of this playing rule, the following interpretations are provided:

"……until cleared…"- Must be in writing

"……Appropriate health-care professional…" - Physician, Neuropsychologist, Nurse Practitioner, Physicians Assistant

Return to Play

The attached forms are examples of a "Notification of Probable Head Injury" and "Return to Play" written authorization. Local school systems may develop forms that best meet their specific circumstances.

Student-Athlete_____

Date of injury _____

Sport _____

Parent/guardian name _____

Home Phone_____

Notification of Probable Head Injury

Dear Parent:

Based on our observations and/or incident described below, we believe your son/daughter exhibited signs and symptoms of a concussion while participating in _____. Since your son/ daughter has not been evaluated by a physician at school, it is important that you seek a physician's care as soon as possible.

It is important to recognize that blows to the head can cause a variety of injuries other than concussions (e.g., neck injuries, more serious brain injuries). Please be sure to see your doctor as soon as possible for any other medical concerns.

Description of Incident/ Injury:_____

_____

_____

When to Seek Care Urgently. If you observe any of the following signs, call your doctor or go to your emergency department immediately.

Headaches that worsen	Very drowsy, can't be awakened	Can't recognize people or places
Seizures	Repeated vomiting	Increasing confusion
Neck pain	Slurred speech	Weakness/numbness in arms/legs
Unusual behavior change	Significant irritability	Less responsive than usual

Common Signs & Symptoms. It is common for a student with a concussion to have one or many symptoms.

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

Please feel free to contact me if you have any questions. I can be reached at:_____

_____ _____

Employee Name and Title Date

TO BE COMPLETED BY THE AUTHORIZED HEALTH CARE PROVIDER:

Name:_____ Signature_____**Date:**_____

Diagnosis:_____

Please be advised that your son/daughter will not be allowed to return to play until they have no symptoms and have been cleared in writing by an authorized health care provider (physician, neuropsychologist, nurse practitioner, physician's assistant) for this type of injury.

Distribution: __Parent __AAM __School Health Room

Student-Athlete_____

Date of injury _____

Today's Date _____

Sport _____

Medical Clearance for Gradual Return to Sports Participation Following Concussion

To be completed by the Authorized Health Care Provider (AHCP)

The above-named student-athlete sustained a concussion. The purpose of this form is to provide initial medical clearance before starting the Gradual Return to Sports Participation, as directed by current medical evidence (2010 AAP Sport-Related Concussion in Children and Adolescents, 2008 Zurich Concussion in Sport Group Consensus).

Criteria for Medical Clearance for Gradual Return to Play (Check each)

The student-athlete must meet all of these criteria to receive medical clearance.

- ☐ **1.** No symptoms at rest
- ☐ **2.** No return of symptoms with typical physical and cognitive activities of daily living
- ☐ **3.** Neurocognitive functioning at typical baseline
- ☐ **4.** Normal balance and coordination
- ☐ **5.** No other medical/ neurological complaints/ findings

Detailed Guidance

1. Symptom checklist: None of these symptoms should be present. Assessment of symptoms should be broader than athlete report alone. Also consider observational reports from parents, teachers, others.

Physical		Cognitive	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			

2. Exertional Assessment (Check): The student-athlete exhibits no evidence of return of symptoms with:
__ **Cognitive activity: concentration on school tasks, home activities (e.g. TV, computer, pleasure reading)**
__ **Physical activity: walking, climbing stairs, activities of daily living, endurance across the day**

3. Neurocognitive Functioning (Check): The student's cognitive functioning has been determined to have returned to its typical pre-injury level by one or more of the following:
__ **Appropriate neurocognitive testing**
__ **Reports of appropriate school performance/ home functioning (concentration, memory, speed) in the absence of symptoms listed above**

4. Balance & Coordination Assessment (Check): Student-athlete is able to successfully perform (SCAT2):
__**Double leg, single leg, tandem stance (20 seconds, no deviations from proper stance)**
__**5 successive Finger-to-Nose repetitions < 4 sec**

I certify that: I am aware of the current medical guidance on concussion evaluation and management; The above-named student-athlete has met all the above criteria for medical clearance for his/her recent concussion, and as of this date is ready to return to a progressive Gradual Return to Sports Participation program (lasting minimum of 5 days).

AHCP Name_____

Signature_____ **Date:**_____

Distribution: __Parent __Athletic Director __School Health Room