ROUND ROCK ISD

Department of Athletic Training - Middle School Concussion Policy

Middle School Coaches should follow the following procedures if they suspect an athlete may have a head injury or has been diagnosed with a concussion.

1. Coaches who observe an athlete with any of the following symptoms after receiving or reporting a blow to the head or has any of the following concussion like symptoms should be suspected of having a concussion.

Headache	Dizziness	Nausea	Ringing in the ears
Irritability	Confusion	Amnesia	Sensitivity to Light
Double Vision	Vomiting	Sleepiness	Misguided Anger
Loss of coordination		Balance issues	Blurred Vision

2. Remove from activity, practice or game, and contact parent. Athlete cannot return to activity that day even if symptoms resolve and/or parent gives consent.
3. Athlete should be cleared by a physician after sustaining any head injury.
4. Once athlete has be symptom free for 24 hours and cleared by a physician, athlete should see high school athletic trainer to begin return to play protocol.
    a. High School athletic trainer will have athlete fill out Concussion Symptom Checklist
    b. Athlete must complete RRISD return to play protocol
    c. Upon completion of RRISD return to play protocol parent, athlete and the Athletic Trainer must sign appropriate UIL Return To Play (RTP) form.
    d. Signed UIL RTP form must be on file with the middle school coaches before the athlete will be allowed to return to full athletic activity.

A middle school athlete, who suffers a second concussion in a six month period, shall not participate in any RRISD athletics, game, practice, or off-season workout even if cleared by a physician.

Documentation Process →

Each suspected concussion should be documented by the Staff Athletic Trainer that performs the initial evaluation.

1) Supervising coach should notify parents as soon as possible.
2) Supervising Coach should notify High School athletic trainer the evening of injury or the following morning
3) Supervising Middle School Coach should fill out Middle School Concussion Form
4) Athlete should be referred to home school Staff Athletic Trainer as soon as possible.
5) Athlete may return to activities once supervising coach has RTP on file signed by home school athletic trainer, parent, and athlete.

Concussion Oversight Team

Physician: Richard T. Strawser, M.D.
Athletic Trainers: John Horsley (WWHS), Salvador Flores (SPHS), Mollie Mauritz (WWHS), Melissa Harrington (CRHS), Melissa Ochs (CRHS), Brooke Kneuper (SPHS), Kirk Mollenkopf (MHS), Maggie Flores-Cook (MHS), Nikki Vincent (RRHS), Matt Owens (RRHS)

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Return to Play Protocol (Criteria)

(1) The return to play protocol follows a stepwise progression of activity until full return. Athlete will fill out a Graded Symptom Checklist daily (preferably around the same time each day) following a concussion. Once all symptoms are graded to be a zero then a return to play protocol will be initiated. Athlete will continue to fill out Graded Symptom Checklist until return to full practice. Generally, each step takes 24 hours to complete. If any concussion symptoms return at any point during the progression, you must return to the beginning of the protocol.

1) Concussion
   a. Day one -Asymptomatic for 24 continuous hours

Must obtain medical clearance from physician before Day 2

   b. Day two -Light aerobic exercise (e.g., stationary bike for 10-15 minutes).
   c. Day three- Training drills and weights. Goal is to have athlete sweat and increase heart rate.
   d. Day four- Sport specific conditioning
   e. Day five - Practice with no contact (e.g., no pads in football).
   f. Day Six-Full contact team practice.
   g. Day Seven-Return to full play

2) Multiple Concussions
   a. Second concussion within a 6 month period: physician clearance, double RTP
   b. Third Concussion (calendar year from occurrence of first concussion): Parent/Guardian, student athlete and COT, including physician, must convene.
      COT decision is final.

3) Post Concussive Syndrome
   a. May do activity at the direction of a physician once diagnosed
   b. Must be symptom free before begin RTP

REFERENCES

1) McCrory, P., et al. Consensus statement on concussion in sport – The 3rd International Conference on concussion in sport, held in Zurich, November 2008. Journal of Clinical Neuroscience, pg. 755-763. Feb. 2009.

2) Summary Statement by the Quality Standards Subcommittee of the American Academy of Neurology. Practice Parameter: The Management of Concussion in Sports. Neurology, pg. 581-585. 1997.

3) National Federation of High School Associations, Suggested Guidelines fot the management of Concussions in Sport; January 2011.

4) University Interscholastic League, Implementation Guide for NFHS Suggested Guidelines for Concussions and Chapter 38, Sub Chapter D of the Texas Education Code.

5) UIL Medical Advisory Committee.

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Name: _____ Date of Injury: _____

Sport: _____ Date: _____

Grade/ Team: _____ Time: _____

How do you feel? You should score yourself on the following symptoms, based on how you feel now.

		None: 0	Mild: 1-2		Moderate: 3-4			Severe: 5-6
1.	Headache	0	1	2	3	4	5	6
2.	"Pressure in head"	0	1	2	3	4	5	6
3.	Neck Pain	0	1	2	3	4	5	6
4.	Nausea or vomiting	0	1	2	3	4	5	6
5.	Dizziness	0	1	2	3	4	5	6
6.	Blurred vision	0	1	2	3	4	5	6
7.	Balance problems	0	1	2	3	4	5	6
8.	Sensitivity to light	0	1	2	3	4	5	6
9.	Sensitivity to noise	0	1	2	3	4	5	6
10.	Feeling slowed down	0	1	2	3	4	5	6
11.	Feeling like "in a fog"	0	1	2	3	4	5	6
12.	"Don't feel right"	0	1	2	3	4	5	6
13.	Difficulty concentrating	0	1	2	3	4	5	6
14.	Difficulty remembering	0	1	2	3	4	5	6
15.	Fatigue or low energy	0	1	2	3	4	5	6
16.	Confusion	0	1	2	3	4	5	6
17.	Drowsiness	0	1	2	3	4	5	6
18.	Trouble falling asleep	0	1	2	3	4	5	6
19.	More emotional	0	1	2	3	4	5	6
20.	Irritable	0	1	2	3	4	5	6
21.	Sadness	0	1	2	3	4	5	6
22.	Nervous or Anxious	0	1	2	3	4	5	6
23.	Ringing in the ears	0	1	2	3	4	5	6

Do symptoms get worse with physical activity? Y N

Do symptoms get worse with mental activity? Y N

Total Number of Symptoms: _____

Symptom Severity Score: _____

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;llsAthlete Name: _____ Date of Injury: _____

Sport /Team: _____ Time of Injury: _____

Concussion History: _____

Description of how the injury occurred:_____

_____

_____

Symptoms at the time of injury: (Circle all that apply)

Headache	Dizziness	Ringing in ears
Blurred vision	Double vision	Irritability
Nausea	Vomiting	Sensitivity to Light
Amnesia	Sleepiness	Aggression/Anger
Repetitive questioning	Confusion	Dazed
Slurred Speech	Slow responses	Coordination Issues

Evaluating Athletic Trainer: _____ Date: _____

Name/Number of Parent Called: _____

Last date w/symptoms: _____

Must be signed by a Medical Doctor

Name of Physician: _____ Date of Visit: _____

Signature of Physician: _____

Cleared to return to activities: Yes No Reasons: _____

_____

Restrictions: _____

_____

Academic Support: ☐Discretion of Athletic Trainer/School Official

☐Other: _____

Section to be completed by Athletic Trainer

Day 1 – Asymptomatic for 24 continuous hours

Day 2 – Stationary Bike – Date: _____ ***Parent Signature:*** **_____**

Day 3 – Training Drills – Date: _____

Day 4 – Sport Specific Conditioning & Weights – Date: _____

Day 5 – Practice with No Contact – Date: _____

FB – Helmet, Shoulder Pads, Shorts, Girdle

Day 6 – Full Athletic Practice – Date: _____

Day 7 – Return To Play – Date: _____

In order for us to give the best possible care to our athletes, we want to follow the treatment plan you have designed for the above athlete. The Sports Medicine Department **requires a hard copy release before an athlete can return to activity from the treating physician.** An athlete will not

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be able to participate without THIS form complete and on file with the school Athletic Trainer. This Form also gives permission to release medical information for above athlete related to his/her injury to become a confidential permanent record of the Sports Medicine Department.

*Athlete must present this completed form to the High School Athletic Trainer

This section to be filled out by Supervising Coach or Contract Athletic Trainer:

Athlete Name: _____ Date of Injury: _____

Coaches Name: _____ Time of Injury:_____ _____

Middle School: _____ Activity: _____

Description of how the injury occurred: _____

_____

_____

_____

Symptoms at the time of injury: (Circle all that apply)

Headache	Dizziness	Ringing in ears
Blurred vision	Double vision	Irritability
Nausea	Vomiting	Sensitivity to Light
Amnesia	Sleepiness	Loss of balance/coordination
Aggression/Anger	Dazed	Repetitive questioning
Slurred Speech	Slow responses	Confusion

This section may be filled out by parent or Supervising Coach

Name of Parent Called: _____

Date of Physician Visit: _____

This Section to be completed by High School Athletic Trainer:

Athlete Name: _____ Date: _____

Last date with symptoms: _____

Concussion Checklist Completion Date: _____

Bike/Treadmill Test Completion Date: _____

Athletic Trainer: _____

Cleared to return to activities: Yes No Reasons: _____

_____

_____

Restrictions: _____

_____

_____