Concussion Oversight Team (COT)

The COT's primary function will be to develop return-to-play and return-to-learn protocols for students believed to have experienced a concussion. The protocols should be based on peer-reviewed scientific evidence consistent with guidelines from the Center for Disease Control and Prevention. These teams can contain a range of individuals based on the resources available to the school in their community or neighborhood but must include one person who is responsible for implementing and complying with the return-to-play and return-to-learn protocols.

DHS COT

Dr. Keith Corpus, MD

Ian Swindler, ATC, ITAT

Cheyenne Dewitt, ATC

Jason Holmes, Athletic Director DHS

Michelle McDonald, BSN, RN

Ashley Seanor, Counselor

Laura Lee, District Nurse

Dustin Hess, Middle School Principal

Brett Cazalet, Football Coach

IHSA Concussion Protocol

1. Any athlete who exhibits signs, symptoms, or behaviors consistent with a concussion shall be immediately removed from the contest and shall not return to play until cleared by an appropriate health care professional. A health care professional is defined as Physicians licensed to practice medicine in all its branches in Illinois (MD/DO), Certified Athletic Trainers (ATC), Advanced Practice Nurses (APN), and Physician Assistants (PA).
2. If it is confirmed by the school's approved health care professional that the student did not sustain a concussion, the head coach may so advise the officials during an appropriate stoppage of play and the athlete may re-enter the contest.
3. Otherwise, if an athlete cannot be cleared to return to play by a school approved health care professional as defined in this protocol, that athlete may not be returned to competition that day and is subject to his or her school's Return to Play (RTP) protocols before the student-athlete can return to practice or competition.

DHS Concussion Oversight Team RTP/RTL Protocol*

- Normal Neurocognitive Test & Concussion Screen
- Symptom Free at Rest for 24 hours
- No School/Classroom Restrictions
- Graded Exercise Completion (gradual return to play)
- Signed IHSA RTP/RTL Consent Form
- Written Clearance by School Athletic Trainer or IHSA Approved Healthcare Professional

*Please note that any athlete that seeks care from a physician is under their physician's care and their physicians protocols. A signed IHSA Post-Concussion Form and written clearance from that physician is necessary for the athlete to return to play. In some cases the physician may release the athlete to the care of the school's athletic trainer. If so, written clearance by the physician must be turned in to the school stating that release to the athletic trainer. In that case, the athletic trainer may provide written clearance for return to play.

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GREAT PLAINS ORTHOPAEDICS

Sports Outreach Concussion/Head Injury Management Plan

Signs and Symptoms of a concussion may include however are not limited to:

Signs: Appears dazed or stunned; blank or vacant look; confusion; forgets assignments/plays; unsure of venue or opponent; moves lethargically or clumsily; answers questions slowly; any loss of consciousness; behavior or personality changes; unable to recall events prior to or after injury; drowsiness; vomiting.

Symptoms: Amnesia; confusion; headache or pressure in the head; loss of consciousness; balance problems; dizziness; double or blurred vision; sensitivity to light or noise; nausea; feeling sluggish, foggy, or groggy; unusually irritable; concentration or memory problems; slowed reaction time.

Immediate Management

- Athlete should immediately be evaluated for Airway, Breathing and Circulation compromise (ABCs). Any compromise of the ABCs should be immediately addressed, the EMS system activated, and athlete transported to the Emergency Department.
- Once the ABCs have been evaluated and addressed, the athlete should be screened for a cervical spine injury. If an athlete is suspected of having a cervical spine injury, the EMS system should be activated, and the athlete should be immobilized and transported to the Emergency Department.
- Any athlete that loses consciousness, as confirmed by the Athletic Trainer, should be immobilized and transported to the Emergency Department via EMS.
- Maxillo-facial injury should be evaluated, and appropriately treated, with any head injury.
- Any athlete suspected of having a concussion should be removed from activity until an evaluation can be completed.

Head Injury/Concussion Sideline Evaluation

- Any athlete suspected of having a concussion should be removed from activity until an evaluation can be completed.
- A clinical and neurologic evaluation should be completed to include review of symptoms, mental status/cognition, oculomotor function, gross sensorimotor, coordination, gait, vestibular function and balance. The currently available baseline assessment can be used to assist with evaluation.
- If a concussion is not suspected and the athlete has a normal evaluation, as described above, the athlete should complete functional drills/activity and be reevaluated. If no change in signs, symptoms or evaluation the athlete should be allowed to return to activity and should be monitored for any changes.
- If a concussion is suspected, all physical activity is to be discontinued until further healthcare provider follow up is obtained.
- During the acute phase (24-48 hours), current recommendations suggest engaging in relative rest, which includes ADLs, reduced screen time, as opposed to complete rest.
    - Avoid stimulation/activity that increases symptoms (eg, screen time, concentration, intense physical activity, present in areas with brightness/loud noises, etc).

- If a concussion is present, and if seen at the time of injury, the athlete should be continually reevaluated for a change in signs, symptoms or evaluation.
- If a concussion is present, and the athlete is stable, they can be released to a parent/guardian or coach if needed. Communication, and documentation of such, with the parent/guardian should occur to discuss injury, guidelines and treatment plan. If releasing to a coach the Athletic Trainer should attempt, and document, contacting the parent/guardian. The written Guidelines for Concussions document should be provided. Documentation should include who the athlete was released to and if the Guidelines for Concussions document was provided.
    - Once determined to be stable, attempt to get the athlete away from stressors (light, noise, etc. - physical and cognitive rest) as soon as possible.
- If the athlete is deteriorating, or is unstable, they should be transported to the Emergency Department via EMS or via parent, as appropriate, based on athlete condition.
- The athlete, and parent/guardian should be instructed to have the athlete follow up with an athletic trainer or a physician/healthcare provider.

Follow up/Evaluation Post Event for an Injury (not the same day as injury)

- If seen in follow up, or evaluated post event for an injury, follow up with the school regard to Return to Learn (RTL) status and academic issues/concerns. A clinical and neurologic evaluation should be completed to include review of symptoms (symptom checklist), mental status/cognition, oculomotor function, gross sensorimotor, coordination, gait, vestibular function and balance. The currently available baseline assessment can be used to assist with evaluation.
- Acute Phase
    - Early return of physical activity, as tolerated, is recommended after the acute phase (24-48 hours). This should only be light intensity activity (e.g. walking or stationary cycling that avoids the risk of contact, collision or fall) that does not exacerbate symptoms.
        - Light aerobic activity could advance in intensity/duration provided there is no or mild exacerbation of symptoms and it briefly returns to pre-exercise levels within an hour.
- Post Acute Phase
    - If the athlete has been asymptomatic for at least 24 hours and successfully completes evaluation as identified above (baseline/normative data can be used as applicable to assist with this), has completed RTL without current academic modifications due to this injury the athlete will be progressed with Return to Play (RTP) Guidelines Steps 3 or 4 -6.
        - Athlete needs to be cleared by AT or healthcare provider to be moved into steps 3 or 4 of the RTP progression.
        - If the athlete is currently symptomatic, they will not be allowed back into sport/contact activity.
- If the athlete is having academic issues, due to their injury, referral to a physician is recommended.
    - Athletes should be encouraged to progress into their normal school/ADL schedule staying below the symptom exacerbation threshold).
- If the athlete is currently symptomatic and/or does not have a normal evaluation, however improving, they are to be instructed to follow up with an athletic trainer or physician/health care provider).
    - If the athlete is still symptomatic and/or does not have a normal evaluation at 1 week status post injury they are recommended to be referred to a physician/healthcare provider.
- The Athletic Trainer should have communication with the parent/guardian, ideally with the athlete present, in regard to injury, status, progression, RTL and RTP. This must be documented.

Return to Play Guidelines –

- General

- RTP guidelines may be modified based on sport and position. Regardless of modification, a progressive functional progression needs to be completed.
- Consideration for a longer RTP progression should be made for athletes with prolonged symptoms and/or resultant inactivity.
- If symptoms become present during RTP progression, the athlete is to discontinue activity and is encouraged to attend practices to be a part of the team and can be allowed to walk (ADL) staying below the symptom exacerbation threshold.
- If the athlete is not able to be seen daily for follow up, the athletic trainer will outline the plan for RTP. The coach and athlete should be instructed to make contact daily with the athletic trainer to update the athlete's status and receive advice on progression.
- All athletes medically cleared for participation by a physician/healthcare provider must complete a RTP progression.
  - If an athlete is cleared to RTP (contact) by a physician, and the athlete is symptomatic; the guardian, athletic director and coach should be contacted, and activity recommendations should be clarified with the physician/healthcare provider prior to initiating contact.
- Disqualifying factors for a season and/or career will be made by qualified, treating healthcare providers.
- Generally, each stage of the RTP progression should take 24 hours.

- The recommended functional progression includes:
  - Step 1 – Symptom Limited Activity
    - ADLs that do not exacerbate symptoms
  - Step 2 – Aerobic Exercise
    - Walking, Stationary Cycling, or light resistance training
      - 2A – Light (approximately 55% of maxHR)
      - 2B – Moderate (approximately 70% of maxHR)
  - Step 3 – Individual Sport Specific Exercise (If this involves any risk of inadvertent head contact, medical clearance for RTP should occur prior to step 3)
    - Training away from team environment
    - Running, changes in direction, individual training drills
  - Step 4 – Non-Contact Drills (Start at when symptoms are resolved for at least 24 hours)
    - Exercises to high intensity
    - Include more challenging training drills
    - Integrate into team environment
  - Step 5 – Full Contact Practice
    - Participate in normal Activities
  - Step 6 – Return to Sport
    - Normal Game Play
- As research continues regarding sport-related concussion, adjustments to this policy can be made in the best interest of the athlete.

References:

- Bloom, J. Vestibular and Ocular Motor Assessments: Important Pieces to the Concussion Puzzle. Athletic Training & Sports Health Care. Vol 5, Number 6 2013.
- Consensus Statement on Concussion in Sport: The 3rd International Conference on Concussion in Sport Held in Zurich, November 2008.
- Consensus Statement on Concussion in Sport: The 4th International Conference on Concussion in Sport Held in Zurich, November 2012.
- Consensus Statement on Concussion in Sport: The 5th International Conference on Concussion in Sport Held in Berlin, October 2016.
- Consensus Statement on Concussion in Sport: The 6th International Conference on Concussion in Sport – Amsterdam, October 2022.
- Heads Up: Brain Injury in Your Practice, Acute Concussion Evaluation (ACE) Care Plan. Centers for Disease Control and Prevention. Gioia, G and Collins, M. 2006.

Post-concussion Consent Form (RTP/RTL)

Date _____

Student's Name _____ **Year in School** 9 10 11 12

By signing below, I acknowledge the following:

1. I have been informed concerning and consent to my student's participating in returning to play in accordance with the return-to-play and return-to-learn protocols established by Illinois State law;
2. I understand the risks associated with my student returning to play and returning to learn and will comply with any ongoing requirements in the return-to-play and return-to-learn protocols established by Illinois State law;
3. And I consent to the disclosure to appropriate persons, consistent with the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), of the treating physician's or athletic trainer's written statement, and, if any, the return-to-play and return-to-learn recommendations of the treating physician or the athletic trainer, as the case may be.

Student's Signature _____

Parent/Guardian's Name _____

Parent/Guardian/s Signature _____

For School Use only

☐ Written statement is included with this consent from treating physician or athletic trainer working under the supervision of a physician that indicates, in the individual's professional judgement, it is safe for the student to return-to-play and return-to-learn.

Cleared for RTL

Date _____

Cleared for RTP

Date _____

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Patient Name & DOB: _____ Date of Evaluation: _____

Follow-up evaluation and revision of recommendations to occur _____.

ACADEMIC ACCOMMODATIONS

Based on today's evaluation, this student was diagnosed with a concussion and the following academic accommodations may help in reducing the cognitive (thinking) load, thereby minimizing post-concussion symptoms and allowing the student to better participate in the academic process during the injury period. **These academic accommodations are recommended as part of medical care and treatment for this medical condition.** The student and parent are encouraged to discuss and establish accommodations with the school on a class-by-class basis. The school and parent may wish to formalize accommodations through a 504 Plan if symptoms persist following treatment and less formalized accommodations.

Current Symptoms: *Symptoms can wax and wane throughout the day and include, and are not limited to:*

☐ Headaches	☐ Sleep Difficulties	☐ Cognitive Difficulties
☐ Nausea	☐ Sensitivity to Light	☐ Visual Dysfunction
☐ Dizziness	☐ Sensitivity to Noise	☐ Environmental Sensitivity
☐ Fatigue	☐ Foggy	

Prognosis: ☐ *Based on today's evaluation, this student is at risk for a prolonged recovery*

Status: *Based on today's evaluation the student is* ☐ Progressing ☐ Stable ☐ Regressing

☐ **Attendance Restrictions:** *Full/partial days missed due to concussion symptoms should be medically excused.*
- ☐ Full days ☐ Modified days ☐ Initiate or Continue homebound education (5 hours per week)
- ☐ No school until _____, then modified days as tolerated until _____, then full days as tolerated.

☐ **Testing:** *Students with concussion have increased memory and attention problems. Highly demanding activities like testing can significantly raise symptoms (e.g., headache, fatigue) which in turn can make testing more difficult, recommendations include:*
- ☐ extra time ☐ test in a quiet environment ☐ allow testing across multiple sessions ☐ reduce length
- ☐ no standardized tests ☐ no tests or quizzes ☐ open note / open book / take home tests
- ☐ reformat from free response to multiple choice or provide cueing (e.g., a notecard for helpful formulas).

☐ **Workload reduction:** *It takes a concussed student much longer to complete assignments. Therefore, it is recommended that "thinking" or cognitive load be reduced, just as physical exertion is reduced.*
- ☐ Reduce overall amount of make-up work, class work, and homework (recommended: 50-75%)
- ☐ Shorten tests and projects ☐ audio books ☐ audit classes ☐ limit computer work

☐ **Note taking:** *Note taking may be difficult due to impaired multitasking abilities and increased symptoms.* Allow student to obtain class notes or outlines ahead of time to aid organization and reduce multi-tasking demands

☐ **Breaks:** *For example, if headache worsens during class, the student should put his/her head on the desk to rest. For worse symptoms, he/she may need to go to the nurse's office to rest prior to returning to class.*

☐ **Extra Time:** *Students are advised to rest, and may need to turn assignments in late on occasion; therefore allow students extra time to complete and turn in assignments.*

☐ **Other Accommodations**
- ☐ Allow for snacks and drinks ☐ Allow student to wear hat and/or sunglasses (sensitivity to light)
- ☐ Report any changes in mood/personality ☐ Change setting (brightness/ contrast) on computer screen
- ☐ No Physical Education Class ☐ No Sports Participation
- ☐ Avoid busy environments (i.e. – leave class early to avoid hallways, cafeteria, and assemblies)
- ☐ _____

Signature_____

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The goal of academic accommodations is to allow the student to continue learning without hindering their recovery from a head injury. School based tasks can provoke symptoms, and protract recovery. Providing the proper accommodations can facilitate recovery, and reduce the negative impact on academic functioning. School tasks should not or only minimally increase symptoms. The following are examples of general recommendations. Recommendations should be individualized for the student.

Attendance: *Students should be excused for inability to attend school due to symptoms of concussion.*
Homebound education: 1 hour of personalized instruction 5 days a week, have student "skype" during classes, do not just send work home expecting student to complete

Half days: Alternate between AM and PM, condense day based on core classes, allow to be in school full days but alternate classes from core class to rest period

Full days: Students performance may wax and wane throughout the day, as well as depending on class subject.

Sensitivity to Light/Noise: Limit loud/noisy environments: eat lunch in a quiet room, no band/music classes, allow for sunglasses, permit student to leave class early to avoid hallways, limit riding on bus

Visual Based Problems: *reduce visual based learning, and promote auditory based learning by* reduced reading, no note taking, limit computer based activities, books/resources on digital media, lectures recorded and listened too, audit classes, have peer read information to student

Dizziness: limit exposure to busy places, limit riding the bus, no note taking, leave class early to avoid hallways, use of school elevator

Cognitive Difficulties: *Short Term Memory, Multitasking, Processing Speed, Attention/Concentration* - Reduced class work, curriculum adapted to essential learning and skills, notes given prior to class to be reviewed, reduction of multi-tasking activities, and/or Pass/Fail
Modifications for tests: Chunking, one page at a time, over several days (extended time), reduce length, quiet environment, no bubble sheets, given orally, and oral responses

Social: *It is important to allow for students to remain connected with the peers* - Allow student to visit peers for limited duration, "Skype", limited participation in extracurricular activities

Fatigue: Allow for breaks throughout the day, rest at nurse's station, put head down in class

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Physical: No physical activity, adaptive gym class

Potential for Prolonged recovery: Some students meet criteria that place them at high risk for a prolonged recovery (greater than 3 weeks). Examples include: neurocognitive data below set criterion cutoffs, vestibular dysfunction, convergence insufficiency, and post traumatic migraines.

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Return to Play Guidelines

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- If symptoms become present during RTP progression, the athlete is to discontinue activity and is encouraged to attend practices to be a part of the team and can be allowed to walk (ADL) staying below the symptom exacerbation threshold.
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    - If an athlete is cleared to RTP (contact) by a physician, and the athlete is symptomatic; the guardian, athletic director and coach should be contacted, and activity recommendations should be clarified with the physician/healthcare provider prior to initiating contact.
- Disqualifying factors for a season and/or career will be made by qualified, treating healthcare providers.
- Generally, each stage of the RTP progression should take 24 hours.

Stage	Description	Date Completed	Athletic Trainer or Coach Signature of Completion
1	Symptom Limited Activity • ADLs that do not exacerbate symptoms		
2	Aerobic Exercise • Walking, Stationary Cycling, or light resistance training		
3	Individual Sport Specific Exercise • Training away from team environment • Running, changes in direction, individual training drills		
4	Non-Contact Drills/Practice		
5	Full Contact Practice		
6	Return to Sport		

OSF
MEDICAL GROUP

Patient Name & DOB: _____

Date of Evaluation: _____

_____ The student named above is cleared for a complete return to full contact sport participation:

- ☐ As of: _____
- ☐ When they have completed the tasks noted below* without symptoms.

The athlete is instructed to stop play immediately and notify the coach or athletic trainer should his/her symptoms return or if they should become symptomatic with any additional contact.

_____ The student is also cleared for a complete return to full academic activity without accommodations:

- ☐ As of: _____
- ☐ When they have completed the tasks noted below* without symptoms.

* Additional Note:

Signature: _____