Sequoia Union High School District
Concussion Information Packet

Athlete/Patient: _____

Date: _____ Time: _____

Referred by (circle one):

- Certified Athletic Trainer/Team Physician/Coach/Other

Name: _____

Contact info: _____

When (check one):

- Now (Emergency Room)
- ASAP (Urgent Care)
- ASAP (Pediatrician/Family Physician)
- Other: _____

Reason for referral: **HEAD INJURY/CONCUSSION:** _____

_____

_____

_____

Referred for formal medical evaluation of head injury. This document must be reviewed and signed by a licensed physician (MD or DO) trained in management of concussion.

Physician name: _____

Impression: _____

_____

_____

Contact info: _____

_____

I am a licensed physician trained in concussion management and have received and reviewed this three page referral form. I have evaluated the athlete referred on this form and conclude d the he/she may gradually return to activity (check one):

- As outlined in the provided return to play protocol (see attached)
- After being seen for a follow-up appointment and before beginning any activity
- Athlete may not return to activity
- Other (please specify)

Specifications: _____

Signature: _____ License #: _____

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TO WHOM IT MAY CONCERN:

You are receiving this sheet because your athlete has suffered a concussion as a result of participation in athletics. Please watch your athlete closely for the next 24-48 hours.

PATIENT INSTRUCTIONS: REST. ***No physical activity until cleared by a Medical Professional.***

Watch for the following signs and symptoms:

- Mental Status changes: lethargy, difficulty maintain arousal, confusion, agitation*
- Vomiting
- Worsening, severe headache
- Decreasing alertness or loss of consciousness
- Weakness on one side of the body
- Decreasing strength
- Decreasing ability to balance
- Seizure or convulsive fit
- Symptoms worsen or do not improve over time
- Increase in number of symptoms reported
- Symptoms begin to interfere with daily activities (sleep disturbances/cognitive difficulties)

……..Or any other abnormal signs that concern you

*** Requires that the athlete be immediately transported to the Emergency Room**

It is ok to:

- Take acetaminophen (Tylenol) for headache
- Use an ice bag on your head or neck for comfort
- Eat a light diet
- Return to work or school
- Go to sleep
- Rest (resume normal activities but no strenuous activity or sports)

There is no need to:

- Check eyes with a flashlight
- Wake up every hour
- Test reflexes
- Stay in bed

Do Not:

- Drink alcohol
- Eat spicy food
- Drive a car
- Use aspirin, Aleve, Advil or other NSAID products

It is not normal for the athlete to experience *symptoms* for several days following a concussion. These symptoms include:

- Headache
- Inappropriate emotions
- Vacant stare/glassy eyed
- Inappropriate behavior
- Loss of sleep
- Worsening headache when trying to focus or concentrate
- Poor Balance
- Nausea/vomiting
- Slurred speech
- Decreased playing ability
- Increased confusion
- Worsening headache
- Easily distracted or poor concentration
- Personality changes
- Loss of appetite
- Irritability
- Dizziness with sudden head movements

You must have written physician (MD/DO) clearance to begin and progress through the following Stages as outlined below (or as otherwise directed by physician)				
Date & Initials	**Stage**	**Activity**	**Exercise Example**	**Objective of the Stage**
	I	No physical activity for at least 2 full symptom-free days **AFTER** you have seen a physician	No activities requiring exertion (weight lifting, jogging, P.E. classes)	Recovery and elimination of symptoms
	II-A	Light aerobic activity	10-15 minutes *(min)* of walking or stationary biking. **Must be performed under *direct supervision* by designated individual**	Increase heart rate to no more than 50% of perceived maximum *(max)* exertion (e.g.,< 100 beats per min) Monitor for symptom return
	II-B	Moderate aerobic activity *(Light resistance training)*	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	Increase heart rate to 50-75% max exertion (e.g.,100-150 bpm) Monitor for symptom return
	II-C	Strenuous aerobic activity *(Moderate resistance training)*	30-45 min running or stationary biking Weight lifting ≤ 50% of max weight	Increase heart rate to > 75% max exertion Monitor for symptom return
	II-D	Non-contact training with sport-specific drills *(No restrictions for weightlifting)*	Non-contact drills, sport-specific activities (cutting, jumping, sprinting) No contact with people, padding or the floor/mat	Add total body movement Monitor for symptom return
Minimum of 6 days to pass Stages I and II. 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				
	III	Limited contact practice	Controlled contact drills allowed (no scrimmaging)	Increase acceleration, deceleration and rotational forces
		Full contact practice Full unrestricted practice	Return to normal training, with contact Return to normal unrestricted training	Restore confidence, assess readiness for return to play Monitor for symptom return
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)*				
	IV	Return to play (competition)	Normal game play (competitive event)	Return to full sports activity without restrictions

Athlete's Name: _____

Date of Concussion Diagnosis_____ Date of Return to competition _____