Concussion Management Guidelines
Revised 4/29/2017

Cerebral concussions represent the most common brain injury in athletics, and scholar-athletes participating in contact and collision sports are particularly vulnerable. A significant head injury may not be readily observable after the initial trauma. Therefore, any scholar-athlete suspected of brain trauma should be thoroughly assessed. The Department of Athletics has adopted standards and guidelines from the NCAA Concussion in Sport Group and the National Athletic Trainers’ Association for the identification, assessment, and return to play guidelines for concussion.

A concussion is a change in brain function caused by a direct or indirect force to the head. It results in a variety of non-specific symptoms and often does not involve loss of consciousness. Concussion should be suspected in the presence of any one or more of the following:

- Symptoms such as headache
- Physical signs such as unsteadiness
- Impaired cognitive function
- Abnormal behavior

SUNY Oneonta Athletic Training Staff and its’ designated team physicians define concussions as non-complex or complex.

A. Non-complex cases – signs and symptoms resolve or significantly improve within a week of initial injury and do not require follow up care with the designated team physician unless the case turns complex.

B. Complex cases – signs and symptoms last longer than a week without significant improvement; signs and symptoms significantly elevate within the Return-to-Learn Protocol; signs and symptoms return after the Return-to-Play Progression has been started; and a scholar-athlete with multiple concussions in one calendar year.

Management of Concussed Scholar-Athletes
SUNY Oneonta makes their concussion management plan publically available on the SUNY Oneonta Athletic Training Website. Scholar-athletes can readily access the Concussion Management Guidelines on SportsWare within their personal account. Guideline components of a concussion management plan are:

1. **Education** - Institutions should provide applicable NCAA concussion fact sheets or other applicable educational material annually to scholar-athletes, coaches, team physicians, athletic trainers, and athletic directors. There should be a signed acknowledgement that all parties have read and understand these concussion facts and their institution’s concussion management plan.
   
   A. The NCAA fact sheet has always been and will continue to be distributed as part of the concussion training with scholar-athletes. The scholar-athletes also sign a Concussion Statement that acknowledges that they have read and understand the concussion facts and SUNY Oneonta’s Concussion Management Plan.
   
   B. Additionally, all scholar-athletes go through concussion education annually every fall conducted by the Athletic Training Staff.
C. Educational training for the SUNY Oneonta Athletic Department staff is required annually before the start of the Fall Athletic Season. The Athletic Department staff will be required to complete the Centers for Disease Control and Prevention (CDC) HEADS UP Training Program, which upon completion of the course will submit a certificate of completion to be filed in the Athletic Training Office. The Athletic Department staff will need to electronically sign the SUNY Oneonta Athletic Department Concussion Statement within ACS. Coaches have been given the concussion fact sheet to keep in their offices which will be updated as new information is given out by the NCAA.

D. Reducing Exposure to Head Trauma Education Plan: While ‘reducing’ may be difficult to quantify, it is important to emphasize ways to minimize head trauma exposure. Examples of minimizing head trauma exposure include, but are not limited to:

1. Adherence to Inter-Association Consensus: Independent Medical Care for College Student – Athletes Best Practices
2. Reducing gratuitous contact during practice
3. Taking a ‘safety first’ approach to sport
4. Taking the head out of contact
5. Coaching and scholar-athlete education regarding safe play and proper technique

2. Pre-Participation/Baseline Testing:

A. Pre-Participation Testing: All varsity scholar-athletes are administered a one-time baseline evaluation when they are a full-time student and rostered scholar-athlete. Any scholar-athlete that sustains a concussion will need to re-baseline before the start of their next athletic season in the following academic year, typically each August or September.

   A. If a scholar-athlete leaves the institution for any reason and then re-enrolls, the scholar-athlete will need to re-baseline.
   B. Any scholar-athlete that is no longer rostered for any reason and is not associated with the Athletic Department will need to re-baseline when the scholar-athlete becomes rostered again.
   C. Any scholar-athlete that is cut from an athletic program and is then rostered on another athletic team will not need to be re-baselined.

1. The evaluation should include, but is not limited to: a cognitive assessment, neurocognitive evaluation, balance assessment, brain injury and concussion history and scholar-athlete reported symptoms.
2. The above listed evaluations will be accomplished through mandated testing with the Concussion Vital Signs (CVS) and/or Standardized Assessment of Concussion (SAC), which is within the SportsWare Online Database.
3. Scholar-athletes of the following sports that will be mandated to undergo computer baseline evaluations, in addition to the postural control assessment, are: Field Hockey, Men’s and Women’s Soccer, Men’s and Women’s Basketball, Men’s and Women’s Lacrosse, Baseball, Softball, Wrestling, Pole Vault, Jumps, and Diving.
4. The athletic training staff, in conjunction with the designated team physician, determines pre-participation clearance and/or the need for additional consultation or testing.
B. Testing Methods

1. Cognitive Assessment - has been shown to provide a rapid evaluation (~5min) of cerebral functioning following concussion. As such, these tests are ideal for the immediate post-injury evaluation. The sensitivity of these tests however, is limited to the first 48 hours post-injury; thereafter more sensitive measures are needed. The Department of Athletics mandates all scholar-athletes at high risk for concussion be administered the Standardized Assessment of Concussion (SAC).

2. Neurocognitive Testing - has been shown to measure subtle differences in information processing speed of scholar-athletes having suffered a concussion versus those that had not. These tests offer a number of promising benefits, including the ability to identify individual differences in pre-season status, to help physicians and certified athletic trainers accurately gauge the effects of an injury, providing early evidence of post-concussion symptoms, unmasking players attempts to hide symptoms, tracking injury status, aiding return to play decision making, reducing the risk of second impact syndrome and helping determine the long term impact of multiple concussions. Neurocognitive tests have been found to be most effective when administered as part of the pre-participation exam, to test the scholar-athlete’s cognitive status before the season, then again when the scholar-athlete no longer reports concussion related symptoms. All testing (baseline and follow-up) should be completed in a room free from noise and distractions. The Department of Athletics mandates all scholar-athletes at high risk for concussion be administered the CVS during the preseason.

3. Balance Testing - has been shown to provide additional objective information to the sports medicine practitioner to support the clinical examination and improve diagnostic sensitivity. Postural control decrements are a common feature of concussion and the Balance Error Scoring System (BESS) allows the quantification of such changes. The BESS can be rapidly (~5min) and easily administered on the sideline and/or in the locker room. The Department of Athletics mandates all scholar-athletes at high risk for concussion be administered the balance error scoring system during preseason through the use of the SAC.

4. Scholar-Athlete Reported Symptoms - represents the easiest and most rapid screening tool for concussion. They are not to be used in isolation of other tests; however, because of the known propensity of scholar-athletes to under-report symptoms in an effort to return to play more rapidly. As such, scholar-athlete reported symptoms should be used only as a guide for when more sophisticated cognitive assessment, neurocognitive and balance tests should be administered. Consistent with the National Athletic Trainers’ Association position statement on concussion management, the Department of Athletics has adopted the Graded Symptom Checklist (GSC) as the standardized symptom reporting form. The Department of Athletics mandates all scholar-athletes at high risk for concussion be administered the GSC during the preseason through the use of the SAC, CVS, and/or a self-report form on the Daily Symptom Sheet.
3. **Evaluation of Suspected Concussion**

A. Medical personnel, such as an athletic trainer or designated team physician, with training in the diagnosis, treatment and initial management of acute concussion must be “present” at all NCAA varsity competitions in the following sports: basketball; field hockey; lacrosse; pole vault; soccer; wrestling.
   1. To be present means to be on site at the campus or arena of the competition. Medical personnel may be from either team, or may be independently contracted.

B. Medical personnel with training in the diagnosis, treatment and initial management of acute concussion must be “available” at all NCAA varsity practices in the following sports: basketball; field hockey; lacrosse; pole vault; soccer; wrestling.
   1. To be available means that, at a minimum, medical personnel can be contacted at any time during the practice via telephone, messaging, email, beeper, or other immediate communication means. Further, the case can be discussed through such communication, and immediate arrangements can be made for the scholar-athlete to be evaluated.

C. At the time of injury or soon after, remove the scholar-athlete suspected of concussion from practice or competition.

D. A certified athletic trainer and/or physician will evaluate the scholar-athlete on the sideline and/or in the locker room/athletic training room.
   1. The clinical examination is supported by a cognitive assessment exam, balance testing and scholar-athlete’s report of symptoms. When possible, the post-injury information should be compared to the baseline/pre-season evaluation.
   2. Scholar-athletes who exhibit signs and symptoms of a concussion through the clinical examination of cognitive assessment, and/or physical and neurological exam, and/or balance test, and/or clinical assessment for cervical spine trauma, skull fracture and intracranial bleed, and/or symptom reports consistent with a concussion diagnosis are removed from the event for the remainder of the calendar day.
   3. Scholar-athletes diagnosed with a suspected concussion will be provided at home instructions outlined in the Concussion Warning Sheet.
   4. Scholar-athletes will be instructed to follow up daily to complete the Daily Symptom Sheet and follow up care.

E. Scholar-athletes demonstrating any of the following should be referred to a physician or medical facility for further evaluation.
   1. Emergency action plan for any possible head injury requiring immediate transport to the emergency room is as follows:
      A. If the injury is sustained on the SUNY Oneonta campus the medical personnel or coach will call University Police Department (UPD) at 607-436-3550, which UPD will dispatch an UPD officer, directly contact the Oneonta Fire Department and Emergency Squad for further care, as well as Oneonta State Emergency Squad (OSES) during the academic calendar year.
      B. If the injury is sustained at an off-campus venue, such as at Fortin Park, Damaschke Field, or Wright Fields, the coach or athletic trainer will contact Oneonta Fire Department and Emergency Squad directly by calling 911.
## Symptoms that require immediate transport to the Emergency Room

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Symptom</th>
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<tbody>
<tr>
<td>Loss of consciousness on the field</td>
<td>Vomiting</td>
</tr>
<tr>
<td>Amnesia lasting longer than 15 min</td>
<td>Cranial nerve deficits</td>
</tr>
<tr>
<td>Deterioration of neurologic function</td>
<td>Increase in blood pressure</td>
</tr>
<tr>
<td>Decreasing level of consciousness</td>
<td>Motor deficits subsequent to initial on-field assessment</td>
</tr>
<tr>
<td>Decrease or irregularity in respirations</td>
<td>Sensory deficits subsequent to initial on-field assessment</td>
</tr>
<tr>
<td>Decrease or irregularity in pulse</td>
<td>Balance deficits subsequent to initial on-field assessment</td>
</tr>
<tr>
<td>Unequal, dilated, or unreactive pupils</td>
<td>Cranial nerve deficits subsequent to initial on-field assessment</td>
</tr>
<tr>
<td>Any signs or symptoms associated with injuries to the spine, skull, or bleeding of the head.</td>
<td>Post-concussion symptoms that worsen</td>
</tr>
<tr>
<td>Mental status declines: lethargy, difficulty maintaining arousal, confusion, or agitation</td>
<td>Additional post-concussion symptoms as compared with those on the field</td>
</tr>
<tr>
<td>Seizure activity</td>
<td></td>
</tr>
<tr>
<td>Prolonged loss of consciousness</td>
<td></td>
</tr>
<tr>
<td>Glasgow Coma Scale &lt;13</td>
<td></td>
</tr>
</tbody>
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### Glasgow Coma Scale

<table>
<thead>
<tr>
<th>Eye Opening Response</th>
<th>Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous--open with blinking at baseline</td>
<td>4 points</td>
</tr>
<tr>
<td>Opens to verbal command, speech, or shout</td>
<td>3 points</td>
</tr>
<tr>
<td>Opens to pain, not applied to face</td>
<td>2 points</td>
</tr>
<tr>
<td>None</td>
<td>1 point</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Verbal Response</th>
<th>Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oriented</td>
<td>5 points</td>
</tr>
<tr>
<td>Confused conversation, but able to answer questions</td>
<td>4 points</td>
</tr>
<tr>
<td>Inappropriate responses, words discernible</td>
<td>3 points</td>
</tr>
<tr>
<td>Incomprehensible speech</td>
<td>2 points</td>
</tr>
<tr>
<td>None</td>
<td>1 point</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Motor Response</th>
<th>Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obeys commands for movement</td>
<td>6 points</td>
</tr>
<tr>
<td>Purposeful movement to painful stimulus</td>
<td>5 points</td>
</tr>
</tbody>
</table>
### F. Scholar-athletes demonstrating normal disposition, cognitive assessment and balance test performance and symptom reports suggesting he/she has not sustained a concussion may return to the event following exertion testing and continued normal presentation.

### 4. **Guidelines for Return – to – Learn After a Concussion**

Return – to – Learn is a parallel concept to Return – to – Play but has received less scientific evaluation. Most times the Return – to – Learn and Return – to – Play occur simultaneously depending on the severity of the concussion. It is in the best interest for the scholar-athlete to be able to return fully to all scholarly activity before returning to their competitive fields. According to the NCAA Concussion Guidelines:

Return-to-Learn guidelines assume that both physical and cognitive activities require brain energy utilization, and that after a sport-related concussion, brain energy may not be available for physical and cognitive exertion because of a brain energy crisis. Return-to-learn should be managed in a stepwise program that fits the needs of the individual, within the context of a multi-disciplinary team that includes physicians, athletic trainers, coaches, psychologists/counselors, neuropsychologists, administrators as well as academic (e.g. professors, deans, academic advisors) and office of disability services representatives. The Return-to-Learn recommendations outlined below are based on expert consensus. Like Return-to-Play, it is difficult to provide prescriptive recommendations for Return-to-Learn. The student-athlete may appear physically normal but may be unable to perform as expected due to concussive symptomatology.

RETURN-TO-LEARN: The first step of return-to-learn is relative physical and cognitive rest, the scholar-athlete will remain at home if they cannot tolerate light cognitive activity. Relative cognitive rest involves minimizing potential cognitive stressors such as school work, video games, reading, testing, and watching television. Consideration should be given to avoiding the classroom for at least the same day as the sport-related concussion. The period of time needed to avoid class or homework is individualized and depends on the symptoms of the scholar-athlete. Progression to Return-to-Learn will be individualized in nature and dependent on the daily Concussion Symptom Evaluator, who will be a member of the SUNY Oneonta Athletic Training Staff. There will be a gradual return to classroom/studying as tolerated. No scholar-athlete shall return to classes on the same day as sustaining a concussion or head injury. As deemed necessary by the Head Athletic Trainer and/or the designated team physician(s), the scholar-athlete would be eligible for accessibility accommodations and should speak to Accessibility Resources; SUNY Oneonta will be in compliance with the ADAAA through Accessibility Resources. The following steps will guide the scholar-athletes progression:

1. After initial diagnosis and if symptoms still exist, an email from Athletic Training Staff will be sent to the scholar-athlete, the coach, faculty athletic representative, Accessibility

<table>
<thead>
<tr>
<th>Withdraws from pain</th>
<th>4 points</th>
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</thead>
<tbody>
<tr>
<td>Abnormal (spastic) flexion, decorticate posture</td>
<td>3 points</td>
</tr>
<tr>
<td>Extensor (rigid) response, decerebrate posture</td>
<td>2 points</td>
</tr>
<tr>
<td>None</td>
<td>1 point</td>
</tr>
</tbody>
</table>
Resources, Student Development, Athletic Administrator, and the scholar-athlete’s faculty to excuse the scholar-athlete for the first 48 - 72 hours of classes, with no classroom activity on the same day as when the scholar-athlete sustains the concussion. Also, the designated team physician will be included on those emails as a blind carbon copy.

A. The scholar-athlete will be required to inform their faculty and communicate on missed class material.
   1. Scholar-athletes will be encouraged to remain at home/dorm if the scholar-athlete cannot tolerate light cognitive activity with gradual return to classroom/studying as tolerated
      a. If symptoms clear within a few days, a follow up email will be sent to the same group clearing the scholar-athlete to return to normal academic activities.
   2. If symptoms continue past the initial 48 - 72 hours, the scholar-athlete will be seen by the designated team physician(s), if the signs and symptoms of the concussion are not improving or are elevated at a severity scores of 3 and above in multiple categories, who will provide a documentation letter that will be provided to Athletic Training and the scholar-athlete. Athletic Training will forward the letter to the scholar-athlete, coach, Accessibility Resources, faculty athletic representative, and Student Development, who will forward it to the student’s faculty. It is then the scholar-athlete’s responsibility to work with Accessibility Resources for any individual accommodations, if deemed necessary.
      A. If a scholar-athlete has signs and symptoms that are below the severity scores of 3 in one or multiple categories, continue past the initial 48 – 72 hours, and are non-complex cases, the scholar-athlete may begin to progress back into classes under the direction of the athletic trainer with consultation of the designated team physician.
      B. Once symptoms resolve and the scholar-athlete can fully return to class without return of signs or symptoms, a follow up email will be sent to the same group clearing the scholar-athlete to return to normal academic activities.
   3. For more complex cases of prolonged Return-to-Learn, the multi-disciplinary team may include, but not limited to:
      1. Designated Team Physician
      2. Head Athletic Trainer
      3. Counseling Center
      4. Health and Wellness Center
      5. Neuropsychologist consultant
      6. Faculty athletic representative
      7. Academic counselor
      8. Course instructor(s)
      9. College administrators
      10. Accessibility Resources
11. Coach(es)

4. Modification of schedule/academic accommodations for up to 2 weeks, as indicated, with help from the Head Athletic Trainer
   A. Re-evaluation by designated team physician and members of the multi-disciplinary team, as appropriate, for scholar-athlete with symptoms lasting longer than 2 weeks.
   B. Utilize Accessibility Resources if the scholar-athlete is having difficulty returning to the classroom activities.

5. The scholar-athlete will need to be signs and symptom free after 2 class days (i.e. go to all classes on both Monday and Tuesday without signs and symptoms returning) before starting the Return-to-Play Progression based upon the discretion of the team physician and/or designee.
   A. Once the scholar-athlete is sign and symptom free, the SAC test and/or CVS test will be administered during the 2 days of classes that are sign and symptom free, based upon the discretion of the team physician and/or designee.
   B. Under the direction of the physician, if the concussion sustained by the scholar-athlete is a complex case, the physician may opt to start the scholar-athlete with physical activity, in accordance to recent concussion research, and direct all threshold testing to be under the supervision of an athletic trainer.
      a. Threshold Testing- bike or jog until signs and symptoms elevate to being bothersome where they can no longer continue without losing balance or be in significant pain. Athletic trainer will time the length of activity and communicate this to the physician.
      b. Based upon the results, the physician will decide how long the scholar-athlete will be allowed to do the low impact activity under the supervision of the athletic trainer, and when to increase the time based upon signs and symptoms.
      c. The physician will instruct when the Return – to – Play progression will begin.
      d. The scholar-athlete will have regular follow ups with the physician until medically cleared or until the physician deems otherwise.
   C. Physician may prescribe or recommend additional therapy or treatment based upon upcoming research or additional services that may be warranted, such as neuropsychology, balance training, memory training, medical specialists, etc., if deemed necessary.
5. **Guidelines for Return to Play after Concussion**

Sport–related concussions are a challenging injury for scholar–athletes and, unlike other injuries, the timeline to be able to return to full activity (including Return-to-Play and Return-to-Learn) is often difficult to project. The psychological response to injury is also unpredictable. It is important that health care providers remain alert to the signs and symptoms of depression and other emotional responses. Because concussions do not result in a consistent injury pattern, all scholar-athletes should be evaluated on an individual basis and Return-to-Play will be determined based on the scholar-athlete’s personal recovery pattern.

***Scholar – athletes with concussions will be withheld from all physical activity (including, but not limited to: practices, competitions, and training) and encouraged to rest cognitively while continuing to report concussion related symptoms and neurocognitive and postural control deficits.

A. Scholar-athletes diagnosed with a concussion will be monitored daily for the presence of and recovery from concussion related symptoms.
   1. Any scholar-athlete that has any of the Graded Symptom Score reporting above a 3 for more than 48 - 72 hours will be required to follow up with SUNY Oneonta’s designated team physician(s).

B. Once a scholar-athlete reports no concussion related symptoms for a full 24 hours, s/he will complete a neurocognitive evaluation and postural control assessment.
   1. The scholar – athlete will be able to complete the neurocognitive evaluation and postural control assessment within the first 24 hours of being signs and symptoms free; however, will need to complete 2 days of rigorous and varying academic work to challenge themselves cognitively without the return of signs and symptoms before beginning their individualized sport Return – To – Play Progressions.
      a) Ideally 48 hours of rigorous and varying academic work would be completing a MWF class schedule and a TR class schedule during the class week; however, due to each concussion that scholar – athletes sustain being different and uncontrolled of when s/he will be signs and symptoms free, it would be acceptable for a scholar-athlete to complete a Friday coursework, continue to do academic work over the weekend with no physical activity allowed and complete a Monday course load to qualify for the 48 hours of rigorous and varying academic work.
   2. If a scholar-athlete does not score within 5% of the baseline, they will need to complete the Concussion Vital Signs and/or SAC again after 24 hours.
   3. After 3 post injury tests without scoring within 5% of the baseline, a scholar-athlete will be referred to the designated team physician(s) for further evaluation.

C. Once the neurocognitive evaluation and balance assessment are equivalent to or better than the baseline test (if available) or age and gender matched norms, a progressive return to play exercise protocol can begin. This may be combined with step 1 of the return to play protocol.
   1. The return to play protocol is as follows*:
      a. *Light aerobic exercise*: walking, swimming or stationary cycling while keeping intensity low for 10-15 minutes
      b. *Unrestricted cardiovascular/Sport-specific exercise*: agility, running drills for 30-45 minutes; no activity that puts the scholar-athlete at risk for head impact
      c. *Non-contact training drills*: Progression to more complex training drills, (e.g., passing drills, offensive drills, and mat work)
d. **Light-contact training drills**: Progression to more complex training drills that include light-contact, small sided, and controlled situations (e.g., 1v1, 2v2, light heading, receiving drills, and light contact mat work/wall dummy work)

e. **Full contact practice**: Following medical clearance, participate in normal training activities

f. **Return to competition**: Normal competition participation or up to 3 days of full practices or upon clearance from the concussion protocol from designated team physician

*Following a stepwise progression, each step should generally take 24 hours so that a scholar-athlete would take approximately one week to proceed through the full rehabilitation protocol once they are asymptomatic at rest and with provocative exercise. Should symptoms return, the scholar-athlete should drop back to the previous asymptomatic level and try to progress again after a further 24-hour period of rest has passed or as dictated by the designated team physician(s).

**No scholar-athlete should return to a contact practice until he/she has been cleared by the designated team physician and/or certified athletic trainer.**

2. For non-complex cases, each phase should generally take 24 hours so that a scholar–athlete would take approximately one week to proceed through the full rehabilitation protocol once they are asymptomatic.

3. For complex cases, each phase can have multiple days and is under the direction of the designated physician(s) on the length of each phase.

D. Evaluation will be required with the designated team physician for a scholar-athlete with prolonged recovery in order to consider additional diagnosis* and best management options.

*Additional diagnoses include, but are not limited to:

- Post-concussion syndrome
- Sleep dysfunction
- Migraine or other headache disorders
- Mood disorders such as anxiety and depression
- Ocular or vestibular dysfunction

E. Any scholar-athlete that sustains multiple concussions in a single collegiate calendar year will be required to follow up with our designated team physician(s), for every concussion after the second.

F. **Sport RTP Lifts and Agility Ladder work outs for the progressions:**

1. **Moderate/Regular Lift**
   a) Warm-up - 5 min
      - Squat - 3x10
      - Push Press - 3x10
      - Lunges - 3x10
      - Pull-Ups (wide grip) - 3x10
      - Partner Hamstring Curls - 3x10
      - Single-Arm DB Row - 3x12
      - Lying Tricep Ext. - 3x12
      - Barbell Bicep Curls - 3x12
2.  **Light Lift**
   a) Push Press - 3x10     Pull-Ups (wide grip) - 3x10
   Bent Over Row - 3x12     Lying Tricep Ext. - 3x12
   3x12     DB Bicep Curls - 3x12
   Upright Row - 3x12     Back Extension - 3x10

3.  **Agility Ladder**
   a) Single Touch     2 in 1 out
   Double Touch     2 in 2 out
   Bunny Hop     Box 2 in 2 out
   Single-Leg Hop     2 in 1 out Hops
   Side Double-Leg Hop     Lateral Double Touch
   Side Single-Leg Hop     Switch Feet Hops
   Carioca     Switch Lunge
   Hops
   “W”/ Zig-Zag

G.  **Sport RTP Progressions:**

1.  **Basketball:**
   a) Phase 1: 15minutes light jogging
   b) Phase 2: 20minutes cardio + 15minutes agility ladder + 10minutes shooting (on own)
   c) Phase 3: 20minutes cardio + 10 full court sprints w/short recovery + 15minutes of individual ball work (shooting, dribbling) + 15minutes agility ladder + 30min lift
   d) Phase 4: Light contact drills + 30minutes cardio (bike/run/elliptical) + 10minutes of suicide sprints + 45min lift
   e) Phase 5: Full practice
   f) Phase 6: Return to competition

2.  **Baseball/Softball:**
   a) Phase 1: 10-15minutes light jogging
   b) Phase 2: 15minutes moderate jogging + 15minutes light throwing (no more than 15ft.)
   c) Phase 3: 30minutes cardio (bike/run/elliptical) including short sprints + 15minutes moderate throwing (30-40ft.) + 15minutes light hitting off a tee + 15min light lift
   d) Phase 4: 30minutes cardio (bike/run/elliptical) including base running (must have clearance before sliding) + 20minutes throwing/pitching (no bullpen) + 20minutes soft toss/hitting off tee + 30min lift
   e) Phase 5: Full practice
   f) Phase 6: Return to competition
3. Cross Country/Track Runners:
   a) Phase 1: 15 minutes light cardio (bike/running/elliptical)
   b) Phase 2: 30 minutes moderate running + 15 minutes interval
   c) Phase 3: 30 minutes run @ decent pace + 30 minute lift + 15 minutes interval bike/run
   d) Phase 4: 30 minutes run @ decent pace + 30 minute lift + 30 minutes interval bike/run
   e) Phase 5: Full workout + 30 minutes lift
   f) Phase 6: Return to competition

4. Jumpers:
   a) Phase 1: 10-15 minutes light cardio (bike/running/elliptical)
   b) Phase 2: 20 min cardio + 15 min lift + 15 min interval
   c) Phase 3: 45 – 60 minutes of rhythmic drills, hopping, excels, sprinting and approaches + 30 min moderate lift
   d) Phase 4: Warm up with team and then- Long and Triple: Short run jumps (10 steps total or less and land on feet) + all rhythmic drills + 30 min lift; High: scissor jumps with approaches + all rhythmic drills + 30 min lift; Pole Vault: take offs w/o inversion (land on feet) + all rhythmic drills + 30 min lift
   e) Phase 5: Full practice (Pole Vault must have clearance from AT for over 11 ft for men or 8 ft for women)
   f) Phase 6: Return to competition

5. Track Throwers
   a) Phase 1: 15 minutes light cardio
   b) Phase 2: 20 min cardio + 15 min lift (50-60% max)
   c) Phase 3: 30 – 45 min of Drill work + 45 min moderate lift (70 – 80% max)
   d) Phase 4: 45 – 75 min drill work with light led ball; hammer turns with no deliver + 30 min lift (70 – 80% max)
   e) Phase 5: Full practice
   f) Return to competition
6. Field Hockey:
   a) Phase 1: 15 minutes light jogging
   b) Phase 2: 20 minutes moderate running + 15 minutes agility ladder + 15 minutes moderate lift
   c) Phase 3: 20 minutes run @ decent pace + 10 minutes interval + 15 minutes of individual stick work (short passing, dribbling, shooting) + 45 minutes moderate lift
   d) Phase 4: (NO SCRIMMAGING) 30 minutes run @ decent pace + 20 minutes of small sided stick work (passing, possession, shooting drills, no corners) + 10 minutes of sprint work + 15 minutes agility ladder + 45 minutes lift

   OR

   Warm-up with team and participate in small sided drills and stick work, perform cardio/agility ladder/sprints when team is scrimmaging and doing corners.

   e) Phase 5: Full practice
   f) Phase 6: Return to competition

7. Men’s Lacrosse:
   a) Phase 1: 10-15 minutes light cardio (bike/running/elliptical)
   b) Phase 2: 20 minutes moderate running + 15 minutes agility ladder + 15 minutes moderate lift
   c) Phase 3: 20 minutes run @ decent pace + 10 minutes interval + 15 minutes of individual stick work (wall ball, shooting) + 45 minutes moderate lift
   d) Phase 4: (NO SCRIMMAGING) 30 minutes run @ decent pace + 20 minutes of small sided stick work (passing, possession, shooting drills, can poke but no checking) + 10 minutes of sprint work + 15 minutes agility ladder + 45 minutes lift

   OR

   Warm-up with team and participate in small sided drills and ball work, perform cardio/agility ladder/sprints when team is scrimmaging.

   e) Phase 5: Full practice (must have clearance from AT before full checking)
   f) Phase 6: Return to competition
8. Women’s Lacrosse:
   a) Phase 1: 10-15minutes light cardio (bike/running/elliptical)
   b) Phase 2: 20minutes moderate running + 15minutes agility ladder + 15minute moderate lift
   c) Phase 3: 20minutes run @ decent pace + 10minutes interval + 15minutes of individual stick work (wall ball, shooting) + 45minute moderate lift
   d) Phase 4: (NO SCRIMMAGING) 30minutes run @ decent pace + 20minutes of small sided stick work (passing, possession, shooting drills) + 10minutes of sprint work + 15minutes agility ladder + 45minute lift

   OR

   Warm-up with team and participate in small sided drills and stick work, perform cardio/agility ladder/sprints when team is scrimmaging.

   e) Phase 5: Full practice
   f) Phase 6: Return to competition

9. Soccer:
   a) Phase 1: 10-15minutes light cardio (bike/running/elliptical)
   b) Phase 2: 20minutes moderate running + 15minutes agility ladder + 15minute moderate lift
   c) Phase 3: 20minutes run @ decent pace + 10minutes interval + 15minutes of individual ball work (passing, juggling, dribbling) + 45minute moderate lift
   d) Phase 4: (NO SCRIMMAGING) 30minutes run @ decent pace + 20minutes of small sided ball work (passing, possession, shooting drills, light heading if allowed) + 10minutes of sprint work + 15minutes agility ladder + 45minute lift

   OR

   Warm-up with team and participate in small sided drills and ball work, perform cardio/agility ladder/sprints when team is scrimmaging.

   e) Phase 5: Full practice (must have clearance from AT regarding full headers)
   f) Phase 6: Return to competition
10. **Swimming (Non-Divers)**
   a) Phase 1: 15 minutes light cardio (bike/jog/elliptical)
   b) Phase 2: 20 minutes cardio (bike/jog/elliptical) + 15 minutes light swim (in own lane, no flip turns, no starts) + 15 min light dryland
   c) Phase 3: 30 minutes endurance swim (in own lane, no flip turns, no starts) + 15 minutes sprint swim (in own lane, no flip turns) + 30 min dryland
   d) Phase 4: 1 hour swim workout (in own lane, must get clearance from ATC to add flip turns and starts) + 1 hour dryland
   e) Phase 5: Full practice (must get clearance from ATC to swim in same lane as others)
   f) Phase 6: Return to competition

11. **Swimming – Divers only**
   a) Phase 1: 15 minutes light cardio
   b) Phase 2: 15 minutes cardio + 15 min interval (bike/run/elliptical) + 15 min drylands
   c) Phase 3: 30 – 45 minutes dry board work or trampoline work + 30 minutes drylands
   d) Phase 4: Feet entry only dives on 1M & 3M (have AT clearance for 3M) or line up entries (NO Half dives and no more than a singular rotation or twist dives) + 30 min dry board work or trampoline work
   e) Phase 5: Full practice
   f) Return to competition

12. **Tennis**
   a) Phase 1: 15 minutes light cardio (run/bike/elliptical)
   b) Phase 2: 20 minutes moderate running + 15 minutes agility ladder + 15 minute moderate lift
   c) Phase 3: 20 minutes cardio (run/bike/elliptical) + 10 minutes interval + 15 minutes of individual work (serves, wall ball) + 45 minute moderate lift
   d) Phase 4: 30 minutes cardio (run/bike/elliptical) + 10 minutes interval + 30 minutes of singles work (serves, forward/back hand with partner) + 45 min lift
   e) Phase 5: Full practice
   f) Phase 6: Return to competition
13. **Volleyball:**
   a) Phase 1: 15 minutes light cardio (bike/jog/elliptical)
   b) Phase 2: 15 minutes cardio (bike/run/elliptical) + 15 minutes agility + 15 minutes light lift
   c) Phase 3: 20 minutes cardio (bike/run/elliptical) + 10 full court sprints + 15 minutes partner volleys and sets (no digs, no receiving serves, no full court drills) + 30 minutes lift
   d) Phase 4: 30 minutes cardio (bike/run/elliptical) + 10 full court sprints + 30 minutes partner volleys, sets, small court plays (must have clearance from ATC for digs and receiving serves, no full court drills) + 45 minutes lift
   e) Phase 5: Full practice
   f) Phase 6: Return to competition

14. **Wrestling:**
   a) Phase 1: 10-15 minutes light cardio (bike/treadmill/elliptical)
   b) Phase 2: 30 minutes moderate cardio + 15 minutes bike interval
   c) Phase 3: 30 minutes + 15 minutes light mat work on own + 15 minutes interval (bike/run) + 30 minutes moderate lift
   d) Phase 4: (NO LIVE) 30 minutes running + 15 minutes light drilling + 15 minutes interval + 15 minutes wall dummy work + 30-45 minutes full lift OR light contact drills in practice, wall dummy drills, and cardio totaling 2 hours of work (NO LIVE)
   e) Phase 5: Full contact practice
   f) Phase 6: Full competition

6. **Daily Symptom Scale**
You should score yourself on the following symptoms based on how you have felt over the past 24 hours (Unless otherwise directed)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>“Pressure in Head”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Neck Pain</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Balance Problems or Dizziness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Nausea or Vomiting</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Hearing Problems/Ringing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>“Don’t Feel Right”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling “Dinged” or “Dazed”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Confusion</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling Like “In A Fog”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Drowsiness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Fatigue or Low Energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>More Emotional Than Usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Irritability</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Difficulty Concentrating/Easily Distracted</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Difficulty Remembering</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sadness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Nervous or Anxious</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Trouble Falling Asleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sleeping More Than Normal</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sensitivity to Light</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sensitivity to Noise</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Vacant Stares/Glassy Eyes</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Seeing Stars/Blurred Vision</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Personality Changes</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling “Slowed Down”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Total Number of Symptoms:** __________________________

**Assessment/Notes/Plan:** ________________________________________________________________

________________________

**Symptoms Severity Score:** _________________

(Add all scores in table, maximum score is 26x6=138)

**AT Name:** __________________________ AT signature & date: __________________________
7. **SUNY Oneonta Concussion Home Care Sheet** – This sheet will be given out to scholar-athletes after they sustain a concussion and serve as an at home care guide.

This is a medical follow-up sheet for your health and safety. Quite often the signs of a concussion do not appear immediately after trauma, but hours after the injury itself. The purpose of this fact sheet is to alert you to the signs and symptoms of concussion that may occur several hours after injury.

**If you experience any of the following symptoms following a head injury, medical help should be sought:**

1. Difficulty remembering recent events or meaningful facts
2. Severe headache, particularly at a specific location
3. Stiffening of the neck
4. Bleeding or clear fluid dripping from the ears or nose
5. Mental confusion or strangeness
6. Nausea or vomiting
7. Dizziness, poor balance, or unsteadiness
8. Weakness in either arm or leg
9. Abnormal drowsiness or sleepiness or inability to sleep
10. Convulsions
11. Unequal pupils
12. Loss of appetite
13. Persistent ringing in the ears
14. Slurring of speech
15. Loss of consciousness

The appearance of any of these symptoms tells you that you have sustained a significant brain injury that requires medical attention. If any of these symptoms appear, it is vital that you notify a member of the Athletic Training Staff and report to the emergency room.

**REMEMBER:** Brain injuries can present signs and symptoms that are often found humorous and/or taken too lightly. To promote recovery, refrain from taking aspirin, ibuprofen, or other pain killers as these may mask serious symptoms indicating need for further medical attention. While at home, please follow the directions below. Your well-being depends on the recognition of these symptoms. Please follow the instructions provided to you by the SUNY Oneonta Athletic Training Staff.

<table>
<thead>
<tr>
<th>DO NOT</th>
<th>IT IS OK TO</th>
<th>There is NO need to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drink Alcohol</td>
<td>Use ice pack on head and neck as needed for comfort</td>
<td>Check eyes with flashlight</td>
</tr>
<tr>
<td>Take aspirin, Ibuprofen, or pain killers</td>
<td>Go to sleep</td>
<td>Wake up every hour</td>
</tr>
<tr>
<td>Do any strenuous activity or sports</td>
<td>Eat a light diet</td>
<td>Test reflexes</td>
</tr>
<tr>
<td>Play video games or watch flashing videos</td>
<td>Take acetaminophen (Tylenol) as directed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rest (no strenuous activity or sports)</td>
<td></td>
</tr>
</tbody>
</table>