

PHYSICIAN CONCUSSION EVALUATION FORM

A.P. SCHALICK HIGH SCHOOL

718 Centerton Road Pittsgrove , NJ 08318 (856) 358-2054 Fax: (856) 358-7512

Mrs. JoAnn Knaub, Nurse

Ms. Dottie Lower, Athletic Trainer

Date: _____

Dear Physician:

_____ has sustained a concussion like injury while participating in _____ at A.P. Schalick High School and has been referred to you for evaluation. The following information provides some background on how we handle head injuries at AP Schalick High School, including computerized neurocognitive testing and return to play guidelines.

At the direction of our school physician, Dr. Bill Madison, and adopted by the Pittsgrove Township Regional Board of Education, A.P. Schalick High School follows the concussion guidelines set forth by the Legislation (P.L. 2010, Chapter 94) (N.J.S.A. 18 A:40-41.3) enacted December 7, 2010.

Return to Play Guidelines

- 1. Immediate removal from competition or practice;**
- 2. School personnel (Athletic Trainer, School Nurse, Coach, etc.) should make contact with the student-athlete's parent/guardian and inform them of the of the suspected sports related concussion or head injury;**
- 3. School personnel (Athletic Trainer, School Nurse, Coach, etc.) shall provide student-athlete with local school district approved information/medical checklist to provide their parent/guardian and physician.**
- 4. Student-athlete must receive written clearance from their physician that student is asymptomatic and may begin the graduated return to play progression. School personnel may consult with school/team physician after medical clearance is given from student-athlete's physician.**

Physician clearance notes inconsistent with the concussion policy may not be accepted and such matters will be referred to our school physicians.

Graduated Return to competition and Practice Protocol

We follow a stepwise activity progression based on recommendations in the Zurich Consensus Statement from the 3rd International Congress on Concussion in Sport as follows:

Step 1: No Activity, complete physical and cognitive rest. The objective of this step is recovery;

Step 2: Light aerobic exercise, which includes walking, stationary cycling, keeping the intensity <70% maximum percentage heart rate:

NO RESISTANCE TRAINING. The objective of this step is increased heart rate;

Step 3: Sport specific exercise including running; no head impact activities. The objective is to add movement;

Step 4: Non-contact training drills (e.g. passing drills). May initiate progressive resistance training;

Step 5: Following medical clearance (consultation between school personnel and student athlete's physician), participation in normal training activities. The objective of this step is to restore confidence and assess functional skills by the coaching staff;

Step 6: Return to play involving normal exertion or game activity.

Each step is separated by 24 hours. If any symptoms occur, the athlete will drop back to the previous level and try to progress again after 24 hours of rest has passed.

ImPACT Testing

In all sports we require pre-season baseline and post-concussion neurocognitive testing using the ImPACT® (Immediate Post Concussion Assessment and Cognitive Testing) software program to assist in the management of head injuries. The 20-minute program is set up in a “Video-game” format. It tracks neurocognitive information such as memory, reaction time, brain processing speed and concentration. We conduct a post-concussive test when the athlete is asymptomatic and continue to test the athlete until their scores return to normal. Please note that this program is used only as a tool in making return to play decisions. Additional information about ImPACT® can be found at www.impacttest.com.

Thank you for your assistance. If you have any questions, please feel free to contact myself, Dr. Bill Madison.

Sincerely,

Dorothy Lower

Athletic Trainer

For the Physician: Please indicate your diagnosis and treatment plan below. Please note that return to sports clearance that is inconsistent with our concussion policy may not be accepted and these matters will be referred to our school physician. Thank you.

Date: _____

Physician’s Diagnosis: _____

Return to Activity

Please check one:

I agree the athlete is cleared for unrestricted sports once he/she meets the criteria outlined in this policy. This includes:

1. Asymptomatic (with no use of medications to mask headache or other symptoms)
2. Completion of Zurich Activity Progression. This may begin once the athlete is asymptomatic for 24 hours.
3. ImPACT scores return to within normal limits of baseline.

I have different recommendations beyond the above recommendations (please specify):

The athlete is to see me again before beginning any physical activity

Additional comments:

Physician’s name (please print): _____

Address: _____

Phone: _____

Physician’s Signature: _____