ATHLETIC CONCUSSION PROTOCOL

Based on Zurich International Concussion Guidelines 2012:
The player should not be left alone during the first 24 to 48 hours following concussion and serial monitoring should be done as necessary. It can be normal for the patient to sleep or nap more following a concussion. However, the patient should go to a hospital if they:

- Have a headache that gets worse, are very drowsy or can't be awakened, can't recognize people or places, have repeated vomiting, behave unusually or seem confused; are very irritable, have seizures (arms and legs jerk uncontrollably), have weak or numb arms or legs, are unsteady on their feet; have slurred speech, or has difficulty understanding speech or directions.
- If the player is 14 or under, has had a previous concussion in the last 12 months or 2 or more concussions prior to this concussion-a minimum of 7 days from time/date of concussion will be used for return to play.
- If the player is 15 or older, without previous concussions in the last 12 months, or only 1 concussion longer than 12 months ago-a minimum of 5 days from time/date of concussion will be used for return to play.
- If an athlete has already been tested with neurocognitive computer testing, it is recommended that a follow-up test be performed after the athlete has been symptom free for 24 hours, but may be done more than once throughout the course of management.

Progression should take approximately 1 week with return to play and only increase a step if asymptomatic on previous step. Steps should be about 24 hours apart:

1.	Rest	24-48 hours post injury or until asymptomatic
2.	Light aerobic activity	Walking, swimming, max HR <70%, no resistance training
3.	Sport Specific Exercise	Skating drills in hockey, running drills in soccer
4.	Non-contact training drills	More complex training drills ex. Passing drills in ice hockey
5.	Full contact practice	All normal practice activities
6.	Return to play	Normal Game Play

If the athletic trainer is concerned that the athlete has been returned to play inappropriately, they will contact the Sports Medicine Medical Director and follow the IHSAA guidelines regarding return to play with concussions. The Sports Medicine Medical Director may require that the athlete by seen by themselves prior to return to play for final clearance in accordance with IHSAA guidelines. All returning athletes from a concussion must have appropriate documentation on file before any practice or competition following a concussion signed by a physician.

SUDDEN CARDIAC SYMPTOMS PROTOCOL

In Accordance with Indiana House Bill 1290, beginning January 2015, any athlete reporting or exhibiting any symptoms related to possible sudden cardiac arrest will be immediately removed from participation in their sport. This includes, but is not limited to:

chest pain **fainting** **dizziness** **shortness of breath** **an abnormally rapid heartbeat** **irregular heart beat**

Once removed from participation, the athlete's parent will be notified and the athlete will not be allowed back into competition until cleared back by the athletic trainer, nurse practitioner or physician. At minimum the athlete will undergo appropriate American Heart Association guidelines screening including history and physical examination. But other more advanced screening or testing may be warranted on a case by case basis in order to adequately clear an athlete back into participation. If an athlete is cleared back and there are any questions or concerns regarding the athlete's clearance, the case will be reviewed by the Medical Director of Sports Medicine at IU Health La Porte Hospital. The Sports Medicine Medical Director may require that the athlete by seen by themselves or a cardiologist prior to return to play for final clearance.

CONSENT FOR TREATMENT, RELEASE OF INFORMATION, AND RETURN TO PARTICIPATION

I understand that if my child sustains an injury during his/her athletic season, the **South Central Jr and Sr High School** Athletic Trainer may disclose injury information to my child's specific coach (or the designated member of that coaching staff), the **South Central Jr and Sr High School** Administration, any treating physicians, and/or Medical Director.

In the event of an injury, I hereby authorize the **South Central Jr and Sr High School** Athletic Trainer to provide sports medicine services to my child. In the event that an injury is suspected or has occurred, the Athletic Trainer will determine whether an athlete may participate and at what capacity. All questions or concerns regarding an athlete's participation may be reviewed by the Team Physician/Medical Director of Sports Medicine at LaPorte Hospital, and a ruling will be directed through the Athletic Trainer. If the athlete is seen by another physician, any treatment to be given by the Athletic Trainer must be authorized in written form. Following a physician release, the Athletic Trainer will determine if an athlete should return to activity based on a complete functional assessment of the athlete and the determination that the athlete is both physically and mentally ready to return. Other services may include, but are not limited to: administering first aid and providing initial treatment and assessment of acute injuries.

As a parent, of a member of a **South Central Jr and Sr High School** athletic squad, I have also read and understand the Athletic Concussion Protocol and Sudden Cardiac Symptom Protocol.

Parent/Guardian Printed Name	**Parent/Guardian Signature**
Student/Athlete's Printed Name	**Date**

Coach Copy

SOUTH CENTRAL ATHLETICS EMERGENCY INFORMATION CARD

Athlete Name: _____ Birthdate: _____ Grade: _____ Sex: M F

Parent(s) Name(s): _____ Primary Phone: _____ Second Phone: _____

Home Address: _____ Town: _____ Zip: _____

Insurance Company/Address: _____

Policy # _____ Group # _____ Person Insured/Policyholder: _____

MEDICAL HISTORY INFORMATION:

Are you allergic to any drugs? Y N If Yes, Explain: _____

Do you have any allergies? Y N If Yes, Explain: _____

Are you on any medication? Y N If Yes, Explain: _____

Do you wear glasses? Y N Contacts? Y N Family Physician: _____ Family Dentist: _____

Previous major injuries/illness/conditions _____

IN CASE OF EMERGENCY, PLEASE CONTACT (IN ORDER OF PREFERENCE:

1. Name: _____ Relation: _____ Phone 1 _____ Phone2 _____

2. Name: _____ Relation: _____ Phone 1 _____ Phone2 _____

3. Name: _____ Relation: _____ Phone 1 _____ Phone2 _____

I hereby give my permission for the school to obtain the services of a dentist, physician, and/or hospital in case the above named student suffers illness and/or accident and the parents/guardians cannot be contacted. I authorize the school officials to take whatever actions considered to be in the best interest of my child. I also understand that a copy of this document will be deemed valid as it's originals.

Parent Signature: _____ Date: _____

Office Copy

SOUTH CENTRAL ATHLETICS EMERGENCY INFORMATION CARD

Athlete Name: _____ Birthdate: _____ Grade: _____ Sex: M F

Parent(s) Name(s): _____ Primary Phone: _____ Second Phone: _____

Home Address: _____ Town: _____ Zip: _____

Insurance Company/Address: _____

Policy # _____ Group # _____ Person Insured/Policyholder: _____

MEDICAL HISTORY INFORMATION:

Are you allergic to any drugs? Y N If Yes, Explain: _____

Do you have any allergies? Y N If Yes, Explain: _____

Are you on any medication? Y N If Yes, Explain: _____

Do you wear glasses? Y N Contacts? Y N Family Physician: _____ Family Dentist: _____

Previous major injuries/illness/conditions _____

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Parent Signature: _____ Date: _____