Corpus Christi
Independent School District

Athletic Training Services

Concussion Return-to-Play Progression Protocols

1. **Concussion determined = athlete out of contest or practice.**

2. **Athlete sees physician of choice = out until written release from THIS Doctor.**

3. **Once Attending Physician written release received = athlete & parents sign concussion information form. Athlete completes 5 step progression supervised by a member of the Concussion Management Team allowing return-to-play.**

   Athlete MUST be symptom free for 24 hours before initiating return-to-play progression.

   Progress continues at 24 hour intervals as long as athlete is symptom free at each level.

   Progression #1= Light aerobic exercise
   Progression #2= Moderate aerobic exercise
   Progression #3= Non-contact training drills in full uniform
   Progression #4= Full contact practice
   Progression #5= Full game play

Instructions for Home Care following Head Injury
(if not seeing a Physician immediately)

1. **No school or work for 24 hours. Athlete is required by state law to see a physician AND follow return-to-play protocols before he/she is allowed to return to any activity.**
   Concentrate on resting during this period.

2. **Water based drinks only for 8 hours**. (Sports drinks, Kool-Aid, Fruit Juice) NO SODA OR MILK.

3. **Eat and Drink sparingly for next 15-24 hours.**

4. **Check patient's pulse and respirations periodically during the first 12 hours.**

5. **You may allow the patient to sleep but check condition every hour while awake and every few hours while asleep.** See that patient responds to pinch or vocal noises or touch and that skin color, pulse and breathing are normal. **Awaken if uncertain of condition.**

6. **Patient is allowed Tylenol as directed, but NO stronger medication.**

7. **Call "9-1-1" if any of the following occur:**

   A. Severe headache that isn't helped with cool wet towels to head or that progressively worsens.
   B. If patient vomits more than two times.
   C. If there is a convulsion.
   D. If the patient complains of weakness or is unable to move one or both of their arms and legs.
   E. If patient becomes sluggish while awake or is unable to be awakened easily if resting.
   F. If there is an abnormal gait, stumbling, or any definitely peculiar behavior.
   G. If there are unusual movements of the eyes, difficulty to focus or one pupil much larger or different than the other.
   H. If breathing rate is less than 10 respirations in one minute or if heart rate is less than 60 beats per minute.

Instrucciones para cuidado en el hogar cuando hay lesión en la cabeza-
(si no ve al Médico inmediatamente)

1. **No asistir a la escuela o trabajo por 24 horas. Se requiere por ley estatal que el Atleta vea un médico Y que siga las reglas necesarias antes de que se le permita regresar a cualquier actividad.** Debe concentrarse en reposar durante este periodo.

2. **Bebidas de agua por 8 horas.** (Bebidas deportivas, Kool-Aid, Jugos de frutas está bien) Ni SODAS O LECHE

3. **Comer y beber periódicamente durante las siguientes 15-24 horas.**

4. **Examinar el pulso y respiraciones del paciente periódicamente durante las primeras 12 horas.**

5. **Puede permitirle al paciente que duerma pero examinar su estado cada hora y también cuando este dormido.** Asegúrese que el paciente responda con un pellizco o a ruido de voces o tacto y que su color de piel, pulso y respiración estén normales. **Despiértelo si esta incierto de su estado**.

6. **Se le permite al paciente tomar Tylenol según las instrucciones, pero NINGUN medicamento más fuerte.**

7. **Llame al "9-1-1" si alguno de los siguientes ocurre:**
   - **A. Fuerte o severo dolor de cabeza que no pueda calmarse con fomentos de agua tibia en la cabeza o si empeora progresivamente.**
   - **B. Si el paciente vomita más de dos veces.**
   - **C. Si sufre una convulsión.**
   - **D. Si el paciente se queja de debilidad o si no puede mover uno o ambos brazos y piernas.**
   - **E. Si el paciente se siente desganado mientras que está despierto o no puede despertar fácilmente mientras reposa.**
   - **F. Si el paciente da paso poco seguro o pierde el equilibrio o de finitamente algún comportamiento peculiar.**
   - **G. Si hay algún movimiento peculiar de los ojos, dificultad de enfocar, o la pupila más grande o diferente que la otra.**
   - **H. Si el ritmo de respiración es menos de 10 respiraciones por minute, o si el ritmo del corazón es menos de 60 latidos por minuto.**

HEAD INJURY/CONCUSSION RETURN TO PLAY AUTHORIZATION

Athlete's Name: _____ **SCHOOL & SPORT: _____**

Date of Injury: _____ **TYPE OF EVENT: GAME/PRACTICE/TRAINING/OTHER**

RISKS OF RETURNING TO PLAY FROM A CONCUSSION

If an athlete prematurely returns to play from a concussion, he/she is at risk for exacerbation of current symptoms or the formation of new symptoms, including, but not limited to:

- **Headache**
- **Dizziness**
- **Ringing in the Ears**
- **Amnesia**
- **Lethargy (Tiredness)**
- **Uncoordinated Movement**
- **Unconsciousness**
- **Post-Concussion Syndrome (prolonged concussion symptoms)**

SECOND IMPACT SYNDROME IS THE GREATEST RISK OF RETURNING TO PLAY TOO QUICKLY. IF AN ATHLETE RECEIVES A SECOND CONCUSSION BEFORE HEALING FROM THE PRIMARY INJURY, HE/SHE IS TERMED TO HAVE SECOND IMPACT SYNDROME, WHICH FEATURES A 50% MORTALITY RATE. AN APPROPRIATE WAITING PERIOD AND RETURN TO PLAY PROGRESSION IS VITAL TO THE SAFETY OF YOUR SONS AND DAUGHTERS.

PHYSICIAN STATEMENT & CONSENT FOR ATHLETE RETURN TO PLAY

After assessing the athlete for and explaining the risks associated with continued participation following a concussion, the athlete is hereby released from my care and may safely begin the Corpus Christi ISD Concussion Management Team's ***"return-to-play protocol"***.

_____ (_____) _____ - _____
Physician's signature Office Phone Number

_____ _____
Physician Name (printed) Office Address

_____
Date of Doctor's Release to Begin Protocol

PARENTAL CONSENT TO RETURN TO PLAY FROM HEAD INJURY

Having been informed that my son/daughter _____ (name) has been diagnosed with a concussion, and of the risks of allowing him/her to return to play, I grant my explicit permission for my son/daughter to return to competition consistent with the Return to Play Protocol prescribed/employed by the Corpus Christi ISD Concussion Management Team. Should my son/daughter suffer further injury (as afore explained) from said return to play, I do hereby indemnify and save harmless the school and any school representative or medical professional from any claim by any person whomsoever on account of such care and treatment of said student. Furthermore, I consent to the disclosure of information regarding this injury to the appropriate persons, consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the treating physician and athletic trainer.

_____ _____

Parent/Guardian Signature Date

Concussion Management Protocol Return to Play Form

This form must be completed and submitted to the athletic trainer or other person (who is not a coach) responsible for compliance with the Return to Play protocol established by the school district Concussion Oversight Team, as determined by the superintendent or their designee (see Section 38.157 (c) of the Texas Education Code).

_____ _____

Student Name (Please Print) *School Name (Please Print)*

Designated school district official verifies:

Please Check

☐ The student has been evaluated by a treating physician selected by the student, their parent or other person with legal authority to make medical decisions for the student.

☐ The student has completed the Return to Play protocol established by the school district Concussion Oversight Team.

☐ The school has received a written statement from the treating physician indicating, that in the physician's professional judgment, it is safe for the student to return to play.

_____ _____

School Individual Signature *Date*

_____

School Individual Name (Please Print)

Parent, or other person with legal authority to make medical decisions for the student signs and certifies that he/she:

Please Check

☐ Has been informed concerning and consents to the student participating in returning to play in accordance with the return to play protocol established by the Concussion Oversight Team.

☐ Understands the risks associated with the student returning to play and will comply with any ongoing requirements in the return to play protocol.

☐ Consents to the disclosure to appropriate persons, consistent with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), of the treating physician's written statement under Subdivision (3) and, if any, the return to play recommendations of the treating physician.

☐ Understands the immunity provisions under Section 38.159 of the Texas Education Code.

_____ _____

Parent/Responsible Decision-Maker Signature *Date*

_____

Parent/Responsible Decision-Maker Name (Please Print)