NCHSAA Concussion Injury History

Student-Athlete's Name: _____ Sport: _____ Male/Female

Date of Birth: _____ Date of Injury: _____ School: _____

Following the injury, did the athlete experience:	Circle one	Duration (write number/ circle appropriate)	Comments
Loss of consciousness or unresponsiveness?	YES | NO	_____ seconds / minutes / hours	
Seizure or convulsive activity?	YES | NO	_____ seconds / minutes / hours	
Balance problems/unsteadiness?	YES | NO	_____ minutes / hrs / days / weeks /continues	
Dizziness?	YES | NO	_____ minutes / hrs / days / weeks /continues	
Headache?	YES | NO	_____ minutes / hrs / days / weeks /continues	
Nausea?	YES | NO	_____ minutes / hrs / days / weeks /continues	
Emotional Instability (abnormal laughing, crying, anger?)	YES | NO	_____ minutes / hrs / days / weeks/ continues	
Confusion?	YES | NO	_____ minutes / hrs / days / weeks /continues	
Difficulty concentrating?	YES | NO	_____ minutes / hrs / days / weeks /continues	
Vision problems?	YES | NO	_____ minutes / hrs / days / weeks /continues	
Other _____ _____	YES | NO	_____ minutes / hrs / days / weeks /continues	

Describe how the injury occurred: _____

_____

_____

Additional details: _____

_____

_____

****

Name of person completing Injury History: _____

Contact Information: Phone Number: _____ Email: _____

Injury History Section completed by: Licensed Athletic Trainer, First Responder, Coach, Parent, Other **(Please Circle)**

Rev June 2017

Licensed Health Care Provider Concussion Evaluation Recommendations

Licensed Health Care Providers (LHCP) are **STRONGLY ENCOURAGED** by the NCHSAA to have expertise and training in concussion management. LHCPs include the following individuals: Licensed Physician (MD/DO), Licensed Athletic Trainer (LAT), Licensed Physician Assistant (PA), Licensed Nurse Practitioner (NP), or Licensed Neuropsychologist.

Name of Athlete: _____ **DOB:** _____ **Date of Evaluation:** _____

All NCHSAA member school student-athletes diagnosed with a concussion are STRONGLY RECOMMENDED to have input and signature from a physician (MD/DO who is licensed under Article 1 of Chapter 90 of the General Statutes and has expertise and training in concussion management) before being cleared to resume full participation in athletics. *Due to the need to monitor concussions for recurrence of signs & symptoms with cognitive or physical stress, Emergency Room and Urgent Care physicians should not make clearance decisions at the time of first visit.* All medical providers are encouraged to review the CDC site if they have questions regarding the latest information on the evaluation and care of the scholastic athlete following a concussion injury. *Providers should refer to NC Session Law 2011-147, House Bill 792 Gfeller-Waller Concussion Awareness Act for requirements for clearance, and please initial any recommendations you select.* (Adapted from the Acute Concussion Evaluation (ACE) care plan (http://www.cdc.gov/concussion/index.html) and the NCHSAA concussion Return to Play Protocol.) The recommendations indicated below are based on today's evaluation.

RETURN TO SCHOOL:

PLEASE NOTE

1. The North Carolina State Board of Education approved "Return-To- Learn after Concussion" policy to address learning and educational needs for students following a concussion.
2. A sample of accommodations is found on the **LHCP Concussion Return to Learn Recommendations** page.

SCHOOL (ACADEMICS):

(LHCP identified below should check all recommendations that apply.)

☐ Out of school until _____/_____/20_____ (date). LHCP Initial: _____ Date: _____

☐ Return for further evaluation on _____/_____/20_____ (date). LHCP Initial: _____ Date: _____

☐ May return to school on _____/_____/20_____ (date) with accommodations as selected on the **LHCP Concussion Return to Learn Recommendations** page. LHCP Initial: _____ Date: _____

☐ May return to school now with no accommodations needed. LHCP Initial: _____ Date: _____

RETURN TO SPORTS:

PLEASE NOTE

A step-by-step progression of physical and cognitive exertion is widely accepted as the appropriate approach to ensure a concussion has resolved, and that a student-athlete can return to athletics safely. The **NCHSAA Concussion Return to Play (RTP) Protocol**, therefore, has been designed using a step-by-step progression and is **REQUIRED** to be completed in its entirety by any concussed student-athlete before they are released to full participation in athletics.

SPORTS & PHYSICAL EDUCATION:

(LHCP identified below should check all recommendations that apply.)

☐ Not cleared for sports at this time.

☐ Not cleared for physical education at this time.

☐ May do light physical education that poses no risk of head trauma such (i.e. walking laps).

☐ May start RTP Protocol under appropriate monitoring and may return to PE activities after completion.

☐ Must return to the examining LHCP for clearance before returning to sports/physical education.

☐ May start the RTP Protocol under monitoring of **First Responder**. The examining LHCP must review progress of student-athlete through stage 4 and before beginning stage 5 either electronically, by phone, or in person and an additional office visit is not required unless otherwise indicated by the LHCP. If the student-athlete has remained free of signs/symptoms after stage 5 is completed, the LHCP must then sign the **RETURN TO PLAY FORM** before the student-athlete is allowed to resume full participation in athletics.

☐ May start the RTP Protocol under monitoring of **LHCP** and progress through all five stages with no office contact necessary unless required by examining LHCP. If student-athlete remains free of signs/symptoms the LHCP must sign the **RETURN TO PLAY FORM** before the student-athlete is allowed to resume full participation in athletics.

Comment: _____

_____ Date: _____

Signature of MD, DO, LAT, PA, NP, Neuropsychologist (Please Circle)

Please Print Name _____

Office Address _____ Phone Number _____

The Licensed Health Care Provider above has delegated aspects of the student-athlete's care to the individual designated below.

_____ Date: _____

Signature of LAT, NP, PA-C, Neuropsychologist, First Responder (Please Circle)

Please Print Name _____

Office Address _____ Phone Number _____

Rev June 2018

Approved for 2021-2022 School Year

Licensed Health Care Provider Concussion Return-To-Learn Recommendations

Licensed Health Care Providers (LHCP) are **STRONGLY ENCOURAGED** by the NCHSAA to have expertise and training in concussion management. LHCPs include the following individuals: Licensed Physician (MD/DO), Licensed Athletic Trainer (LAT), Licensed Physician Assistant (PA), Licensed Nurse Practitioner (NP), or Licensed Neuropsychologist.

Name of Athlete: _____ **DOB:** _____ **Date:** _____

Following a concussion, most individuals typically need some degree of cognitive and physical rest to facilitate and expedite recovery. Activities such as reading, watching TV or movies, playing video games, working/playing on the computer and/or texting require cognitive effort and can worsen symptoms during the acute period after concussion. Navigating academic requirements and a school setting present a challenge to a recently concussed student-athlete. A Return-To-Learn policy facilitates a gradual progression of cognitive demand for student-athletes in a learning environment. Licensed Health Care Providers should consider whether academic and school modifications may help expedite recovery and lower symptom burden. It is important to the review academic/school situation for each student athlete and identify educational accommodations that may be beneficial.

Educational accommodations that may be helpful are listed below.

Return to school with the following supports:

Length of Day

__ Shortened day. Recommended ____ hours per day until re-evaluated or (date) _____.
__ ≤ 4 hours per day in class (consider alternating days of morning/afternoon classes to maximize class participation)
__ Shortened classes (i.e. rest breaks during classes). Maximum class length of _____ minutes.
__ Use _____ class as a study hall in a quiet environment.
__ Check for the return of symptoms when doing activities that require a lot of attention or concentration.

Extra Time

__ Allow extra time to complete coursework/assignments and tests.
__ Take rest breaks during the day as needed (particularly if symptoms recur).

Homework

__ Lessen homework by _____ % per class, or _____ minutes/class; or to a maximum of _____ minutes nightly, no more than _____minutes continuous.

Testing

__ No significant classroom or standardized testing at this time, as this does not reflect the patient's true abilities.
__ Limited classroom testing allowed. No more than _____ questions and/or _____ total time.
    __ Student is able to take quizzes or tests but no bubble sheets.
    __ Student able to take tests but should be allowed extra time to complete.
__ Limit test and quiz taking to no more than one per day.
__ May resume regular test taking.

Vision

__ Lessen screen time (SMART board, computer, videos, etc.) to a maximum _____ minutes per class AND no more than _____ continuous minutes (with 5-10 minute break in between). This includes reading notes off screens.
__ Print class notes and online assignments (14 font or larger recommended) to allow to keep up with online work.
__ Allow student to wear sunglasses or hat with bill worn forward to reduce light exposure.

Environment

__ Provide alternative setting during band or music class (outside of that room).
__ Provide alternative setting during PE and/or recess to avoid noise exposure and risk of injury (out of gym).
__ Allow early class release for class transitions to reduce exposure to hallway noise/activity.
__ Provide alternative location to eat lunch outside of cafeteria.
__ Allow the use of earplugs when in noisy environment.
__ Patient should not attend athletic practice
__ Patient is allowed to be present but not participate in practice, limited to ___ hours

Additional Recommendations:

_____

_____

NCHSAA Virtually Monitored Concussion Return to Play Protocol

Circumstances may arise when there is no LHCP or first responder readily available to supervise a student-athlete's Concussion Return to Play (RTP) Protocol (in-person). In those instances, the NCHSAA Virtually Monitored Concussion RTP V-Monitored Concussion RTP Protocol offers a reasonable alternative to ensure safe progression of a student-athlete through the concussion RTP protocol.

- The NCHSAA Concussion Return to Play (RTP) Protocol (in-person) OR the NCHSAA Virtually Monitored Concussion RTP is **REQUIRED** to be completed in its entirety for any concussed student-athlete (SA) before they are released to resume participation in athletics. A step-by-step progression of physical and cognitive exertion is widely accepted as the appropriate approach to ensure a concussion has resolved, and that a student-athlete can return to athletics safely. Both the NCHSAA Concussion (RTP) Protocol and NCHSAA Virtually Monitored Concussion (RTP) Protocol have been designed using this step-by-step progression.
- The NCHSAA Virtually Monitored Concussion (RTP) Protocol can be monitored by any of the following LHCP: Licensed Physician, Licensed Athletic Trainer, Licensed Physician Assistant, Licensed Nurse Practitioner or a Licensed Neuropsychologist.
- The LHCP may elect to use a combination of in-person monitoring and virtual monitoring to complete the required stages within the RTP progression. Both in-person and virtual stage monitoring outcomes can be documented on this form.
- After monitored completion of each stage without provocation/recurrence of signs and/or symptoms, a student- athlete is allowed to advance to the next stage of activity. The length of time for each stage is at least 24hours. A separate stage specific in-person/virtual consult checklist is to be completed for each RTP stage.
- An adult observer must be present with the SA during each stage to provide consent and assist with emergency care if needed.

Stage	Activity	Objective	Stage Specific Virtual Consult Checklist Completed/ In-Person Monitored
1	20-30 min of cardio activity: walking, stationary bike	Perceived intensity/exertion: Light Activity	☐ YES DATE _____ ☐ YES In-Person Monitored
2	30 min of cardio activity: jogging at medium pace. Body weight resistance exercise (e.g. Push-ups, lunge walks) with minimum head rotation x25 each.	Perceived intensity/exertion: Moderate Activity	☐ YES DATE _____ ☐ YES In-Person Monitored
3	30 min of cardio activity: running at fast pace, incorporate intervals. Increase repetitions of body weight resistance exercise (e.g. Sit-ups, push-ups, lunge walks) x 50 each. Sport specific agility drills in three planes of movement.	Perceived intensity/exertion: Hard activity, changes of direction with increased head and eye movement	☐ YES DATE _____ ☐ YES In-Person Monitored
4	Participate in non-contact practice drills. Warm-up and stretch x10 min. Intense, non-contact, sport specific agility drills x 30-60 minutes.	Perceived intensity/exertion: High/Maximum Effort Activity	☐ YES DATE _____ ☐ YES In-Person Monitored
5	Participate in full practice. If in a contact sport, controlled contact practice allowed.		☐ YES DATE _____ ☐ YES In-Person Monitored
Final LHCP Virtual Visit	The LHCP overseeing the SA's care will review RTP in its entirety (including Stage 5). If any concussion signs or symptoms occur during stage 5, the SA is required to return to the treating LHCP. The Virtually Monitored RTP Packet and the RTP Form MUST be signed by supervising LHCP before the SA is allowed to resume full participation in athletics.		☐ YES DATE _____ ☐ YES In-Person Monitored

The LHCP who monitored the student athlete's RTP Protocol MUST sign and date below when stage 5 is successfully completed.
By signing below, I attest that I have monitored the above-named student-athlete's return to play protocol through stage 5.

_____ _____

Signature of Licensed Physician, Licensed Athletic trainer, Licensed Physician Assistant, Licensed Nurse Practitioner, Licensed Neuropsychologist (please circle)

Date

_____

Please print name

NCHSAA Virtually Monitored Concussion RTP Protocol - VIRTUAL CONSULT CHECKLIST – STAGE 1

STUDENT-ATHLETE'S NAME: _____ DOB: _____

ADULT OBSERVER: _____ DATE: _____ TIME: _____

MONITORED BY: _____ (circle one) MD/DO, LAT, PA, NP Licensed Neuropsychologist

☐ Conducted through a video telemedicine source with double identification verified. Athlete & adult voice understanding and consent to proceed with exertional stage via interactive audio and video telemedicine source.

☐ Review of athlete's overall function with activities of daily living (cognitive and physical): _____% normal

Comment:

☐ **Pre-Exercise Symptom Questionnaire**

- Review and report symptoms the athlete is experiencing in the last 24 hours BEFORE starting RTP stage
- If athlete reports symptoms BEFORE or DURING exercise, session should NOT continue. Notification of and consultation with supervising physician is recommended.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Other:		
Sensitivity to light			Confusion					

Monitored Observation of RTP Stage – Light Activity

20-30 minutes of cardio activity (walking/stationary bike):

☐ **Post- Exercise Symptom Questionnaire**

- Review and report symptoms the athlete is experiencing AFTER completing RTP stage.
- If athlete reports symptoms AFTER exercise or 24 hours following, notification of and consultation with supervising physician is recommended.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Comment:		
Sensitivity to light			Confusion					

☐ Education on monitoring for red flags

☐ Establish plan for next virtually supervised visit – DATE _____ TIME _____ CONFIRMED BY _____

NCHSAA Virtually Monitored Concussion RTP Protocol - VIRTUAL CONSULT CHECKLIST – STAGE 2

STUDENT-ATHLETE'S NAME: _____ DOB: _____

ADULT OBSERVER: _____ DATE: _____ TIME: _____

MONITORED BY: _____ (circle one) MD/DO, LAT, PA, NP Licensed Neuropsychologist

☐ Conducted through a video telemedicine source with double identification verified. Athlete & adult voice understanding and consent to proceed with exertional stage via interactive audio and video telemedicine source.

☐ Review of athlete's overall function with activities of daily living (cognitive and physical): _____% normal

Comment:

☐ **Pre-Exercise Symptom Questionnaire**

- Review and report symptoms the athlete is experiencing in the last 24 hours BEFORE starting RTP stage
- If athlete reports symptoms BEFORE or DURING exercise, session should NOT continue. Notification of and consultation with supervising physician is recommended.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Other:		
Sensitivity to light			Confusion					

☐ **Monitored Observation of RTP Stage –** Moderate Activity

30 min of cardio activity (jogging at medium pace):
Body weight resistance exercise with minimum head rotation (e.g. Push-ups, lunge walks):

☐ **Post- Exercise Symptom Questionnaire**

- Review and report symptoms the athlete is experiencing AFTER completing RTP stage.
- If athlete reports symptoms AFTER exercise or 24 hours following, notification of and consultation with supervising physician is recommended.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Comment:		
Sensitivity to light			Confusion					

☐ Education on monitoring for red flags

☐ Establish plan for next virtually supervised visit – DATE _____ TIME _____ CONFIRMED BY _____

NCHSAA Virtually Monitored Concussion RTP Protocol - VIRTUAL CONSULT CHECKLIST – STAGE 3

STUDENT-ATHLETE'S NAME: _____ DOB: _____

ADULT OBSERVER: _____ DATE: _____ TIME: _____

MONITORED BY: _____ (circle one) MD/DO, LAT, PA, NP Licensed Neuropsychologist

☐ Conducted through a video telemedicine source with double identification verified. Athlete & adult voice understanding and consent to proceed with exertional stage via interactive audio and video telemedicine source.

☐ Review of athlete's overall function with activities of daily living (cognitive and physical): _____% normal

Comment:

☐ **Pre-Exercise Symptom Questionnaire**

- Review and report symptoms the athlete is experiencing in the last 24 hours BEFORE starting RTP stage
- If athlete reports symptoms BEFORE or DURING exercise, session should NOT continue. Notification of and consultation with supervising physician is recommended.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Other:		
Sensitivity to light			Confusion					

☐ **Monitored Observation of RTP Stage -** Hard activity, changes of direction with increased head and eye movement

30 min of cardio activity: (running at fast pace, incorporate intervals)
Increase repetitions of body weight resistance exercise (e.g. Sit-ups, push-ups, lunge walks):
Sport specific agility drills in three planes of movement:

☐ **Post- Exercise Symptom Questionnaire**

- Review and report symptoms the athlete is experiencing AFTER completing RTP stage.
- If athlete reports symptoms AFTER exercise or 24 hours following, notification of and consultation with supervising physician is recommended.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Other:		
Sensitivity to light			Confusion					

☐ Education on monitoring for red flags

☐ Establish plan for next virtually supervised visit – DATE _____ TIME _____ CONFIRMED BY _____

NCHSAA Virtually Monitored Concussion RTP Protocol - VIRTUAL CONSULT CHECKLIST – STAGE 4

STUDENT-ATHLETE'S NAME: _____ DOB: _____

ADULT OBSERVER: _____ DATE: _____ TIME: _____

MONITORED BY: _____ (circle one) MD/DO, LAT, PA, NP Licensed Neuropsychologist

☐ Conducted through a video telemedicine source with double identification verified. Athlete & adult voice understanding and consent to proceed with exertional stage via interactive audio and video telemedicine source.

☐ Review of athlete's overall function with activities of daily living (cognitive and physical): _____% normal

Comment:

☐ **Pre-Exercise Symptom Questionnaire**

- Review and report symptoms the athlete is experiencing in the last 24 hours BEFORE starting RTP stage
- If athlete reports symptoms BEFORE or DURING exercise, session should NOT continue. Notification of and consultation with supervising physician is recommended.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Other:		
Sensitivity to light			Confusion					

☐ **Monitored Observation of RTP Stage –** High/Maximum Effort Activity

Warm-up and stretch x10 min: Participate in non-contact practice drills. Intense, non-contact, sport specific agility drills x 30-60 minutes:

Post- Exercise Symptom Questionnaire

- Review and report symptoms the athlete is experiencing AFTER completing RTP stage.
- If athlete reports symptoms AFTER exercise or 24 hours following, notification of and consultation with supervising physician is recommended.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Comment:		
Sensitivity to light			Confusion					

☐ Education on monitoring for red flags

☐ Establish plan for next virtually supervised visit – DATE _____ TIME _____ CONFIRMED BY _____

NCHSAA Virtually Monitored Concussion RTP Protocol - VIRTUAL CONSULT CHECKLIST – STAGE 5

STUDENT-ATHLETE'S NAME: _____ DOB: _____

ADULT OBSERVER: _____ DATE: _____ TIME: _____

MONITORED BY: _____ (circle one) MD/DO, LAT, PA, NP Licensed Neuropsychologist

☐ Conducted through a video telemedicine source with double identification verified. Athlete & adult voice understanding and consent to proceed with exertional stage via interactive audio and video telemedicine source.

☐ Review of athlete's overall function with activities of daily living (cognitive and physical): _____% normal

Comment:

☐ **Pre-Exercise Symptom Questionnaire**

- Review and report symptoms the athlete is experiencing in the last 24 hours BEFORE starting RTP stage
- If athlete reports symptoms BEFORE or DURING exercise, session should NOT continue. Notification of and consultation with supervising physician is recommended.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Other:		
Sensitivity to light			Confusion					

☐ **Monitored Observation of RTP Stage 5 –** Participate in full practice. SPORT: _____

☐ A "Stage 5 equivalent" workout that incorporates high intensity, high heart rate activity that challenges the vestibular, visual, and cognitive systems can be substituted when there is not an opportunity to participate in a team-based practice.

Please describe in detail the practice/workout activities that the athlete participated in.

Post- Exercise Symptom Questionnaire

- Review and report symptoms the athlete is experiencing AFTER completing RTP stage.

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Comment:		
Sensitivity to light			Confusion					

*If athlete reports symptoms AFTER exercise or 24 hours following, notification of supervising physician is recommended.

NCHSAA Virtually Monitored Concussion RTP Protocol – FINAL VIRTUAL CONSULT CHECKLIST

(To be completed by supervising LHCP)

STUDENT-ATHLETE'S NAME: _____ DOB: _____

ADULT OBSERVER: _____ DATE: _____ TIME: _____

MONITORED BY: _____ (circle one) MD/DO, LAT, PA, NP Licensed Neuropsychologist

☐ Conducted through a video telemedicine source with double identification verified. Athlete & adult voice understanding and consent to proceed with visit via interactive audio and video telemedicine source.

☐ Review of athlete's overall function with activities of daily living (cognitive and physical): _____% normal

Comment:

☐ **Symptom Questionnaire**

	Yes	No		Yes	No		Yes	No
Headache			Sensitivity to noise			Drowsiness		
"Pressure in head"			Feeling slowed down			Trouble falling asleep		
Neck Pain			Feeling "like in a fog"			More emotional		
Nausea or vomiting			"Don't feel right"			Irritability		
Dizziness			Difficulty concentrating			Sadness		
Blurred vision			Difficulty remembering			Nervous or anxious		
Balance problems			Fatigue or low energy			Other:		
Sensitivity to light			Confusion					

☐ **Review of RTP Stage 5 –** Participate in Full Practice

Comment:

☐ **Additional Comments:**

☐ Athlete has successfully completed all 5 stages of the RTP protocol without recurrence of concussion related symptoms.

☐ Athlete has returned to pre-injury function level and reports no concussion related clinical signs and symptoms at rest and with cognitive stimulation (schoolwork, reading, computer work).

☐ NCSHAA Gfeller-Waller Virtually Monitored RTP Protocol Packet completed and kept on file.

☐ The **RETURN TO PLAY FORM: Concussion Medical Clearance Releasing the Student-Athlete to Resume Full Participation in Athletics** is completed and kept on file with a copy provided to the student-athlete's parent/legal custodian

CONCUSSION RETURN TO PLAY FORM:
MEDICAL CLEARANCE RELEASING THE STUDENT-ATHLETE TO RESUME FULL PARTICIPATION IN ATHLETICS

This form must be signed by one of the following examining Licensed Health Care Providers (LHCP) identified in the Gfeller-Waller Concussion Awareness Act before the student-athlete is allowed to resume full participation in athletics: Licensed Physician (MD/DO), Licensed Athletic Trainer (LAT), Licensed Physician Assistant (PA), Licensed Nurse Practitioner (NP), or Licensed Neuropsychologist. This form must be signed by the student-athlete's parent/legal custodian giving their consent before their child resumes full participation in athletics.

Name of Student-Athlete: _____ Sport: _____ Male/Female

DOB: _____ Date of Injury: _____ Date Concussion Diagnosed: _____

This is to certify that the above-named student-athlete has been evaluated and treated for a concussion and that the Return to Play Protocol was monitored by:

_____ at _____.

(Print Name of Person and Credential) (Print Name of School)

As the examining LHCP, I attest that the above-named student-athlete is now reporting to be completely free of all clinical signs and reports he/she is entirely symptom-free at rest and with both full cognitive and full exertional/physical stress and that the above-named student-athlete has successfully completed the required NCHSAA Concussion Return to Play Protocol through stage 5. By signing below therefore, I give the above-named student-athlete consent to resume full participation in athletics.

It is critical that the medical professional ultimately releasing this student-athlete to return to athletics after a concussion has appropriate expertise and training in concussion management. The NCHSAA, therefore, STRONGLY RECOMMENDS that in concussion cases, Licensed Athletic Trainers, Licensed Physician Assistants, Licensed Nurse Practitioners, consult with their supervising physician before signing this Return To Play Form, as per their respective state statutes.

_____ _____

Signature of Licensed Physician, Licensed Athletic Trainer, Licensed Physician Assistant, Licensed Nurse Practitioner, Licensed Neuropsychologist (Please Circle) Date

_____

Please Print Name

_____ _____

Please Print Office Address Phone Number

****

Parent/Legal Custodian Consent for Their Child to Resume Full Participation in Athletics

I am aware that the NCHSAA **REQUIRES** the consent of a child's parent or legal custodian prior to them resuming full participation in athletics after having been evaluated and treated for a concussion. I acknowledge that the Licensed Health Care Provider above has overseen the treatment of my child's concussion and has given their consent for my child to resume full participation in athletics. By signing below, I hereby give my consent for my child to resume full participation in athletics.

_____ _____

Signature of Parent/Legal Custodian Date

_____

Please Print Name and Relationship to Student-Athlete

Rev: July 2021