Northborough-Southborough Regional School District Head Injury and Concussions Protocol

For Extracurricular Athletic Activities

I. Training Program

A. Education and Training for Personnel Employed in the Northborough-Southborough Regional School District(NSRSD)

1. Before beginning any extracurricular athletic activity coaches, volunteers for athletic activities, medical providers employed by NSRSD, school nurses, athletic director, referees and umpires who are employees, contractors, or agents of the school; whether employed by the school or school district or serving in such a capacity as a volunteer shall complete one of the training programs approved by the Department of Public Health that will include information on the prevention and recognition of a sports-related injury, including second impact syndrome.
2. The training and education will be repeated each subsequent year.

B. Education and Training for Students and Parents

1. Each year at the required pre-season meeting for every sport, the Athletic director will provide current Department of Public Health (DPH) approved materials to all students who plan to participate in extracurricular athletic and their parents in advance of the student's participation. Such materials at minimum include a summary of the DPH's rules relative to safety including but not limited to recognition of symptoms of head injury, the biology and short-term and long-term consequences of concussion, second impact syndrome and rules to return to play after a head injury or concussion.
2. The student and parent shall submit as a pre-requisite to participate in extracurricular athletics a signed acknowledgement as to the receipt of information and completion of on-line training.
3. The training and education will be repeated every subsequent year.

II. Documentation of Head Injury and Concussion History

A. At or before the start of each sport season, all students who plan to participate in extracurricular athletics shall complete and submit to the Athletic director the current approved Permission Form, signed by both the student and the parent, that provides comprehensive history; any head, face or cervical spine injury history, and any history of co-existent concussive injuries.

B. The Athletic Director shall ensure that all forms that are required by 105 CMR 201.009(B) (1) are distributed to each coach. The coaches will ensure that all forms are completed and submitted to the Athletic director for review. Copies of forms, which indicated a history of head injury/concussion, must be given to the school nurse.
C. An incident report must be completed by the coach and forwarded to the school nurse and athletic director when a student sustains a head injury or concussion during a game or practice. A parent must inform the school nurse if the injury occurs outside of those settings. The school nurse will forward this information to the Athletic director so he/she can inform the coach.

III. Suspected Concussion Exclusion from Play

A. Any student, who during a practice or competition, sustains a head injury or suspected concussion, or exhibits signs and symptoms of a concussion, shall be removed from the practice or competition immediately and may not return to the practice or competition that day.
B. The student shall not return to play until the student provides medical clearance and authorization as specified in 105 CMR 201.011.
C. The coach/athletic trainer/designee shall communicate the nature of the injury directly to the parent in person or by phone immediately after the game or practice in which a student has been removed from play for a head injury or suspected concussion. The coach also must provide this information to the parent in writing by the end of the next business day.
D. The coach or his/her designee shall communicate, by the end of the next business day, with the Athletic Director that the student has been removed from play for a head injury or suspected concussion and complete and submit the approved accident report. The Athletic Director will give a copy of the report to school nurse.

1. Each student who is removed from play and subsequently diagnosed with a concussion shall have medical documentation regarding the reentry to school academics and extracurricular activities given to the school nurse. The school nurse will communicate the plan to the athletic director, assistant principal for the student's grade, guidance, and teachers, and appropriate school staff.
2. The student must be symptom free and medically cleared in order to begin the graduated reentry to extracurricular athletic activities.

IV. Medical Clearance and Authorization to Return to Play

A. Each student who is removed from play for a head injury or suspected concussion shall obtain and present to the coach/athletic trainer and school nurse the approved Return to Athletic Participation Form prior to resuming the extracurricular athletic activity. A physician or one of the individuals as authorized by 105CMR 201.011(A) must complete this form. The only individuals that may authorize a student to return to play are:

1. Certified athletic trainer in consultation with a licensed physician; or
2. Neuropsychologist after the student has been examined and cleared by a licensed physician.

V. Record Maintenance:

A. The district will maintain relevant and required records in accord with 105 CMR 201.015.

B. Records will be kept with the school nurse/athletic director as deemed appropriate.

VI. Reporting

A. The district shall be responsible for maintaining and reporting annual statistics on a Department of Public Health form or electronic format that at a minimum reports:

1. The total number of Report of Head Injury Forms received by the school; and
2. The total number of students who incur head injuries and suspected concussions when engaged in any extracurricular athletic activities.

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

JUDYANN BIGBY, MD
SECRETARY

JOHN AUERBACH
COMMISSIONER

REPORT OF HEAD INJURY DURING SPORTS SEASON

This form is to report head injuries (other than minor cuts or bruises) that occur during a sports season. It should be returned to the athletic director or staff member designated by the school and reviewed by the school nurse.

For Coaches: Please complete this form immediately after the game or practice for head injuries that result in the student being removed from play due to a *possible* concussion.

For Parents/Guardians: Please complete this form if your child has a head injury outside of school related extracurricular athletic activities.

Student's Name	Sex	Date of Birth	Grade
School		Sport(s)	
Home Address		Telephone	

Date of injury: _____

Did the incident take place during an extracurricular activity? _____ Yes ____ No

If so, where did the incident take place? _____

Please describe nature and extent of injuries to student:

For Parents/Guardians:
Did the student receive medical attention? yes_____ no_____
If yes, was a concussion diagnosed? yes____ no _____

I HEREBY STATE THAT TO THE BEST OF MY KNOWLEDGE, MY ANSWERS TO THE ABOVE QUESTIONS ARE COMPLETE AND CORRECT.
Please circle one: Coach or Marching Band Director Parent/Guardian

Name of Person Completing Form (please print): _____

Signature _____ Date _____

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health

POST SPORTS-RELATED HEAD INJURY MEDICAL CLEARANCE AND AUTHORIZATION FORM

This medical clearance should be only be provided *after* a graduated return to play plan has been completed and student has been symptom free at all stages. ***The student must be completely symptom free at rest and during exertion prior to returning to full participation in extracurricular athletic activities.***

Student's Name	Sex	Date of Birth	Grade

Date of injury: _____ Nature and extent of injury: _____

Symptoms (check all that apply):

☐ Nausea or vomiting ☐ Headaches ☐ Light/noise sensitivity

☐ Dizziness/balance problems ☐ Double/blurry vision ☐ Fatigue

☐ Feeling sluggish/"in a fog" ☐ Change in sleep patterns ☐ Memory problems

☐ Difficulty concentrating ☐ Irritability/emotional ups and downs ☐ Sad or withdrawn

☐ Other

Duration of Symptom(s): _____ Diagnosis: ☐ Concussion ☐ Other: _____

If concussion diagnosed, date student completed graduated return to play plan without recurrent symptoms: _____

Prior concussions (number, approximate dates): _____

Name of Physician or Practitioner: _____

☐ Physician ☐ Certified Athletic Trainer ☐ Nurse Practitioner ☐ Neuropsychologist

Address: _____ Phone number: _____

Physician providing consultation/coordination (if not person completing this form): _____

I HEREBY AUTHORIZE THE ABOVE NAMED STUDENT FOR RETURN TO EXTRACURRICULAR ATHLETIC ACTIVITY.

Signature: _____ Date: _____

Note: This form may only be completed by: a duly licensed physician; a certified athletic trainer in consultation with a licensed physician; a duly licensed nurse practitioner in consultation with a licensed physician; a duly licensed neuropsychologist in coordination with the physician managing the student's recovery.

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

JUDYANN BIGBY, MD
SECRETARY

JOHN AUERBACH
COMMISSIONER

PRE-PARTICIPATION HEAD INJURY/CONCUSSION REPORTING FORM FOR EXTRACURRICULAR ACTIVITIES

This form should be completed by the student's parent(s) or legal guardian(s). It must submitted to the Athletic Director, or official designated by the school, *prior* to the start of each season a student' plans to participate in an extracurricular athletic activity.

Student's Name	Sex	Date of Birth	Grade
School		Sport(s)	
Home Address			Telephone

Has student ever experienced a traumatic head injury (a blow to the head)? Yes_____ No_____

If yes, when? Dates (month/year): _____

Has student ever received medical attention for a head injury? Yes_____ No_____

If yes, when? Dates (month/year): _____

If yes, please describe the circumstances:

Was student diagnosed with a concussion? Yes_____ No_____

If yes, when? Dates (month/year): _____

Duration of Symptoms (such as *headache, difficulty concentrating, fatigue*) for most recent concussion: _____

Parent/Guardian:
Name: _____Signature/Date _____
(Please print)

Student Athlete:
Signature/Date _____